DISCUSSION PAPER

MENTAL HEALTH PROVISIONS OF THE HOSPITALS ACT

Law Reform Commission of Nova Scotia
September 2000

101-00036/

WHAT DO YOU THINK?

The Law Reform Commission is very interested in what you think about the issues raised in the Discussion Paper, *Mental Health Provisions of the Hospitals Act*.

We have attempted, as much as possible, to describe the mental health provisions of the *Hospitals Act*, as well as some of the problems associated with them, in a way that can be understood by people who are not lawyers and who are not familiar with the legal system. This Discussion Paper does not represent the final views of the Commission. It is designed to encourage discussion and public participation in the work of the Commission. Your comments will assist us in preparing a Final Report for the Minister of Justice. The Final Report will contain recommendations on how the mental health provisions of the *Hospitals Act* should be reformed.

If you would like to comment on the Discussion Paper, you may:

- Fax the Commission at (902) 423-0222
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In order for us to fully consider your comments before we prepare our Final Report, please contact us by **December 8, 2000.**

Please note that the Final Report will list the names of individuals and groups who make comments or submissions on this Discussion Paper. Unless comments are marked confidential, the Commission will assume respondents agree to the Commission quoting from or referring to comments made. Respondents should be aware that the Nova Scotia *Freedom of Information and Protection of Privacy Act* may require the Commission to release information contained in submissions.

The Law Reform Commission of Nova Scotia was established in 1991 by the Government of Nova Scotia under an *Act to Establish an Independent Law Reform Commission.*

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The Commission's work is available on the Internet through the Chebucto Community Net at http://www.chebucto.ns.ca/Law/LRC and also from links at the Government of Nova Scotia Web site (http://www.gov.ns.ca/).

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MENTAL HEALTH PROVISIONS OF THE *HOSPITALS ACT*

SUMMARY

In 1997, the Minister of Justice and Attorney General of Nova Scotia referred the study of the mental health provisions of the *Hospitals Act* to the Law Reform Commission. The *Hospitals Act* governs psychiatric facilities in Nova Scotia, and in particular, how people are admitted to psychiatric facilities, what rights and entitlements they have on admission, the conditions of their stay, and how they are discharged.

A psychiatric "facility" is defined in the *Act* as a hospital or part of a hospital "used for the observation, care and treatment of persons suffering from psychiatric disorder." In this Paper, a psychiatric disorder is defined as a severe mental health problem usually associated with impaired functioning due to a biological, chemical, genetic, physical, psychological, or social disturbance.

Admission to a psychiatric facility

A person can be admitted to a psychiatric facility in two ways, with consent (voluntary admission) or without consent (involuntary admission). For voluntary admission, in addition to the person's consent, a qualified physician must indicate that the person requires "in-patient" services at the facility. An in-patient remains at a facility 24 hours a day, in order to receive medical and nursing attention, until discharged. The involuntary admission of a person to a psychiatric facility usually takes place on the basis of two medical certificates issued by physicians, each of whom has examined the person. The medical certificates must state that the physician has reasonable and probable grounds to believe that the person suffers from a psychiatric disorder, and that the person should be admitted because he or she needs in-patient services and requires care that cannot be adequately provided outside the facility, because he or she is a danger to his or her own safety or the safety of others. Involuntary admission can also take place by transfer from another facility, by warrant or order under the *Criminal Code* or another statute, by judicial order, or through the intervention of a peace officer.

One is admitted as a "person for observation" with respect to most routes of entry under the *Hospitals Act*. A person under observation is admitted to a facility for the purpose of an examination and psychiatric assessment. A psychiatric assessment involves the determination of the presence or absence of a psychiatric disorder. A person may remain under observation for up to seven days. After expiry of the observation period, the person may be discharged, or may remain in a facility as a voluntary or involuntary patient. A voluntary patient remains in a facility as long as the patient consents and a physician recommends the patient's continued admission. Once declared an involuntary patient, a person may be detained in a facility for an initial detention period which can last up to one month. A declaration of involuntary admission may be renewed to extend the period of detention for two successive three month periods and thereafter for six month periods. The detention of a patient under an involuntary admission

certificate lasts, subject to statutory time limits, until the patient is discharged by a psychiatrist, the Supreme Court of Nova Scotia, or the Psychiatric Facilities Review Board.

Treatment

The *Hospitals Act* requires a person to be examined within three days of admission to a facility in order to have determined his or her capacity to consent to treatment. Mental capacity is an individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors. After the examination, the psychiatrist must complete a "declaration," which states whether in the psychiatrist's opinion the person examined is capable of consent to treatment. In general, no treatment may be administered without consent unless the person does not have the capacity to consent. Treatment can, however, proceed even in the face of a refusal if the person is deemed incapable of consenting to the treatment, and if consent of a "substitute decision-maker" is obtained. A substitute decision-maker or "proxy" is a person appointed to make a health care decision on behalf of someone else. A substitute decision-maker can be appointed through an "advance health care directive," a legal document in which a person sets out how his or her health care is to be managed in the event of mental incapacity. Appointment of a substitute decision-maker can also occur under authority of the *Hospitals Act* or of a guardianship order.

Patients' property and finances

Competency to administer one's financial affairs is also decided by a psychiatrist. Similar to a capacity declaration, upon completion of an examination, the psychiatrist must provide a declaration concerning the examined person's competency to administer his or her estate, that is, everything that a person owns.

Review of decisions

If a patient believes that a decision affecting him or her was wrong or unfair, he or she can apply to have the decision "reviewed" or reconsidered, by a decision-maker external to the facility. The Psychiatric Facilities Review Board has the authority to review declarations involving capacity or competency, as well as issues involving detention, treatment, or care. For all issues, with the exception of treatment or care, the board has the power to make a binding order. For treatment or care, the review board can only make recommendations. The Supreme Court of Nova Scotia can review an involuntary patient's status upon application by the patient or his or her representative. The Supreme Court may also review declarations of capacity or competency.

Specific rights of patients and persons under observation

The *Hospitals Act* specifies certain rights for patients and persons under observation at a psychiatric facility. Generally, a person will be able to communicate freely by mail, to make

unmonitored telephone calls, and to receive visitors. Written advice is to be provided regarding letters, telephone use, visits, legal representation, file review, and review of capacity or competency declarations. A person in a facility is to be given assistance in understanding any document, in contacting a lawyer, and in applying for a review. For the most part, the confidentiality of health information, relating to persons presently or formerly in a hospital, is also protected.

Preliminary suggestions for reform

The Commission seeks public commentary to assist in developing recommendations for reforming the mental health provisions of the *Hospitals Act*. In particular, the Commission invites comments on its preliminary suggestions, including:

- The term "mental disorder" should be used rather than "psychiatric disorder." "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life. The Commission seeks comments on what, if any, conditions should be specifically mentioned in the definition of mental disorder.

- The Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder not only when bodily harm is likely to self or others, but also when there is a likelihood of causing psychological harm to self.

- The standard time period for completion of a psychiatric assessment should be 24 hours, with a possibility for an additional 48 hours in exceptional cases.

- Peace officers should be permitted to leave a facility during the time that a person apprehended and brought in by the officers is being assessed. To avoid any misunderstandings, consent for peace officers to depart a facility should be in writing.

- Facility staff should be required to inform peace officers when an assessment is completed and a person who had been brought to a facility by peace officers is not admitted as an involuntary patient.

- A declaration of formal admission should be renewable for a one month period, followed if needed by a two month period, in turn followed by a three month period. Any additional renewal periods would be for three months.

- The *Hospitals Act* should require that prior to receiving a particular treatment, a patient must provide his or her informed consent. This would mean that the patient was informed about the nature of the treatment, its expected benefits, its material risks, its

material side effects, any alternative courses of action, and any likely consequences of not having the treatment.

- A person should be presumed to be mentally capable and a capacity determination should take place only when an issue arises about a patient's capacity, not simply because the person is a patient in a psychiatric facility.

- In addition to psychiatrists, other specially qualified health care professionals should be permitted to complete capacity assessments. Organizations of health care professionals should determine what combination of training and experience would allow someone to meet the required qualifications.

- The statute should specifically allow for treatment to be administered without consent to a person who is incapable with respect to consent to the treatment, if there is an emergency.

- Leave certificates should be made available in Nova Scotia for certain involuntary patients. In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. The patient must be considered likely, because of the mental disorder, to cause bodily harm to self or others, to cause psychological harm to self, or to suffer imminent and serious impairment if the patient does not receive continuing treatment or care and supervision while living in the community. A collaborative treatment plan must be developed, to which the patient or the patient's representative consents.

- Training should be provided for all review board appointees. Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

- Review boards should provide written reasons for their decisions.

- The review board should not be empowered to require a patient's appearance at a hearing.

- The *Act* should provide for a rights adviser at each psychiatric facility. A rights adviser would be entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation. A rights adviser should be knowledgeable about rights of application to a review board, the nature and procedures of the review boards, and how to obtain legal services.

- If a facility wishes to deny a patient access to his or her record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to convince the board why denial of access would be reasonable.

- The disclosure of the relevant portion of the patient's health record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or safety.

- The *Hospitals Act* should permit a patient, otherwise entitled to view his or her record, to require that corrections be made, or statements of disagreement be added, to a record.

- To promote consistency, clarity, and efficiency in aspects of mental health law, changes to the *Hospitals Act* should be undertaken as part of a wider statute which addresses mental health issues generally. If the creation of a wider mental health statute would involve undue delays, then the Commission's proposals should take the form of amendments to the current *Hospitals Act*.

LES DISPOSITIONS DE LA *LOI SUR LES HOPITAUX* RELATIVES A LA SANTE MENTALE

SOMMAIRE*

En 1997, le Ministre de la Justice et Procureur Général de la Nouvelle-Ecosse a référé à la Commission de réforme du droit l'étude des dispositions de la *Loi sur les hôpitaux* relatives à la santé mentale. La *Loi sur les hôpitaux* régit les établissements psychiatriques en Nouvelle-Ecosse et plus particulièrement la façon dont les personnes y sont admises, leurs droits et privilèges après admission, les conditions de leur séjour et de leur départ.

Un « établissement » psychiatrique est défini dans la *Loi* comme un hôpital ou partie d'un hôpital « servant à l'examen, aux soins et traitement des personnes souffrant de troubles psychiatriques ». Dans le présent document, troubles psychiatriques signifie un problème sérieux de santé mentale résultant habituellement d'une capacité de fonctionnement diminuée en raison de troubles biologiques, chimiques, génétiques, physiques, psychologiques ou sociaux.

Admission dans un établissement psychiatrique

Un individu peut être admis dans un établissement psychiatrique de deux façons : avec son consentement (admission volontaire) ou sans son consentement (admission involontaire). Dans le cas d'admission volontaire, en plus du consentement de l'individu, un médecin qualifié doit déclarer que cette personne requière des services « hospitaliers » dans cet établissement. Le patient hospitalisé demeure à l'établissement 24 heures par jour pour y recevoir des soins médicaux et infirmiers jusqu'à son départ. L'admission involontaire d'une personne dans un établissement psychiatrique se fait habituellement sur la base de deux certificats médicaux signés par deux médecins ayant chacun examiné la personne. Les certificats médicaux doivent déclarer que le médecin possède des motifs probables et raisonnables de croire que la personne souffre de troubles psychiatriques et qu'elle doit être admise dans cet établissement car elle requière des soins qui ne peuvent lui être prodigués adéquatement hors l'établissement parce que son état menace sa sécurité et celle des tiers. L'admission involontaire peut aussi résulter d'un transfert d'un établissement à l'autre, d'un mandat ou ordonnance émise en vertu du *Code Criminel* ou d'une autre loi, d'une ordonnance d'un tribunal ou de l'intervention d'un agent de la paix.

Une personne peut être admise à titre de « patient sous observation » peut importe la méthode d'admission permise par la *Loi sur les hôpitaux*. Une personne sous observation est admise dans un établissement aux fins d'examen et d'évaluation psychiatriques. Une évaluation psychiatrique vise à déterminer la présence ou l'absence de troubles psychiatriques. Une personne peut demeurer sous observation jusqu'à sept jours. A l'expiration de la période

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d'observation, le patient peut-être renvoyé de l'établissement ou peut y demeurer à titre de patient volontaire ou involontaire. Un patient volontaire demeure dans l'établissement aussi longtemps que dure le consentement du patient accompagné de l'avis du médecin à l'effet que le patient doive continuer à y demeurer. Une fois déclaré patient involontaire, un individu peut être retenu dans un établissement pour une période de détention initiale d'un mois maximum. Une déclaration d'admission involontaire peut être renouvelée afin d'augmenter la période de détention à deux périodes de trois mois successives et par la suite à des périodes de six mois. La détention d'un patient en vertu d'un certificat d'admission involontaire dure, sous réserve des limites statutaires, jusqu'à ce que le patient soit libéré par un psychiatre, par la Cour Suprême de la Nouvelle-Ecosse ou par la Commission de révision des établissements psychiatriques.

Traitement

La *Loi sur les hôpitaux* exige l'examen d'une personne dans les trois jours de son admission dans un établissement afin de déterminer son aptitude à consentir au traitement. L'aptitude mentale est la capacité d'une personne à décider après mûre réflexion en prenant en considération les risques, les bénéfices et d'autres facteurs. Subséquemment à cette détermination, le psychiatre doit remplir une « déclaration » laquelle indique si le psychiatre est d'avis que la personne examinée possède l'aptitude mentale pour consentir au traitement. En général, aucun traitement ne peut être administré sans le consentement de la personne sauf si la personne ne possède pas l'aptitude mentale nécessaire pour donner son consentement. Un traitement peut cependant être administré même si la personne l'a refusé dans le cas où cette personne est présumée inapte à donner son consentement au traitement et si le consentement d'un « décideur substitut » est obtenu. Un décideur substitut ou « mandataire » est la personne désignée par une autre pour prendre des décisions médicales à sa place. Un décideur substitut peut être désigné par une « déclaration anticipée de soins médicaux », qui consiste en un document ayant valeur juridique dans lequel la personne circonscrit les soins médicaux qu'elle recevra en cas d'inaptitude mentale. La nomination d'un décideur substitut peut aussi se faire sous l'autorité de la *Loi sur les hôpitaux* ou d'une ordonnance de nomination d'un gardien.

Les biens et affaires financières du patient

Le psychiatre décide aussi de l'aptitude d'une personne à administrer ses affaires financières. A l'instar d'une déclaration d'aptitude mentale, après examen, le psychiatre doit produire une déclaration sur l'aptitude d'une personne à administrer son patrimoine, c'est-à-dire, tout ce qu'une personne possède.

Révision des décisions

Dans le cas où un patient serait d'avis qu'une décision à son sujet est erronée ou inéquitable, il peut faire une requête auprès d'une autorité externe à l'établissement en question et demander que la décision soit "révisée" ou examinée à nouveau. La Commission de révision des

établissements psychiatriques est compétente pour réviser les déclarations relatives à l'aptitude ou à la capacité de même que celles impliquant la détention, les traitements ou les soins. En ce qui concerne tous ces sujets, sauf les traitements et les soins, la Commission de révision possède l'autorité nécessaire à l'émission d'une ordonnance ayant force exécutoire. En ce qui concerne les traitements et les soins, la Commission de révision ne peut que faire des recommandations. Sur requête d'un patient ou de son représentant, la Cour Suprême de la Nouvelle-Ecosse peut réviser le statut d'un patient involontaire. La Cour Suprême de la Nouvelle-Ecosse peut réviser les déclarations d'aptitude mentale ou de capacité.

Droits spécifiques des patients et personnes sous observation

La *Loi sur les hôpitaux* prévoit des droits spécifiques au profit des patients et personnes sous observation dans un établissement psychiatrique. De façon générale, une personne pourra communiquer librement avec l'extérieur par la poste, par des appels téléphoniques privés et par des visites à l'établissement. Des recommandations écrites doivent être fournies en ce qui concerne les lettres, l'usage du téléphone, les visites, la représentation juridique, la révision de dossier et la révision des déclarations d'aptitude mentale et de capacité. La personne à l'intérieur de l'établissement doit recevoir de l'aide pour comprendre des documents, contacter un avocat et faire une demande de révision. En règle générale, la confidentialité de l'information médicale des personnes présentement dans un hôpital ou qui y ont séjourné est aussi protégée.

Recommandations de réforme préliminaires

La Commission invite le public à lui faire part de ses commentaires afin d'aider à l'élaboration de recommandations visant à réformer les dispositions de *la Loi sur les hôpitaux* relatives à la santé mentale. Plus particulièrement, la Commission invite le public à commenter les recommandations préliminaires suivantes:

- L'expression "troubles mentaux" devrait être utilisée en lieu et place de "troubles psychiatriques." "Troubles mentaux" devrait être défini ainsi: trouble important de la pensée, de l'humeur, des capacités cognitives, de l'orientation ou de la mémoire qui diminue de façon significative le jugement, le comportement, la capacité de voir la réalité ou l'habilité à faire face aux exigences normales de la vie. La Commission invite le public à commenter sur la question de savoir si des maladies devraient être spécifiquement mentionnées dans la définition de "troubles mentaux."

- La législation néo-écossaise devrait prévoir l'admission involontaire d'une personne souffrant de troubles mentaux non seulement en raison de menaces à son intégrité physique ou à celle de tiers, mais aussi en raison de menaces de dommages psychologiques.

- Le délai normal pour mener à terme une évaluation psychiatrique devrait être de 24 heures avec une période additionnelle de 48 heures dans des cas exceptionnels.

- Les agents de la paix ayant arrêté une personne et l'ayant livrée à un établissement devraient avoir le droit de quitter l'établissement durant l'évaluation psychiatrique. Afin d'éviter tout malentendu, le consentement au départ des agents de la paix devrait être donné par écrit.

- Le personnel de l'établissement devrait avoir l'obligation d'informer les agents de la paix lorsque l'évaluation est terminée et que la personne amenée par les agents de la paix n'est pas admise dans l'établissement à titre de patient involontaire.

- La déclaration d'admission formelle devrait être renouvelable pour une période d'un mois suivie, le cas échéant, d'une période de deux mois et d'une autre période de trois mois. Tout renouvellement additionnel serait pour une période de trois mois.

- La *Loi sur les hôpitaux* devrait prévoir qu'avant de recevoir des traitements, un patient doit donner son consentement. Ceci implique que le patient ait été préalablement informé de la nature des traitements, des résultats escomptés, des risques importants, des effets secondaires importants, des alternatives possibles et des conséquences si les traitements ne sont pas administrés.

- Une personne devrait être présumée mentalement apte et une évaluation d'aptitude mentale ne devrait être effectuée que si l'aptitude mentale de la personne est remise en question, et non simplement en raison du fait que la personne est un patient dans un établissement psychiatrique.

- En sus des psychiatres, d'autres professionnels de la santé qualifiés devraient pouvoir effectuer les évaluations d'aptitude mentale. Les corps de professionnels de la santé devraient déterminer quelles combinaisons de formation et d'expérience sont nécessaires pour qu'un professionnel soit considéré qualifié pour mener ces évaluations.

- En cas d'urgence, la loi devrait permettre spécifiquement que des traitements puissent être administrés sans le consentement de la personne si elle est incapable de consentir.

- Les certificats de départ devraient être disponibles en Nouvelle-Ecosse pour certains patients involontaires. Pour qu'un certificat de départ soit émis, le patient doit souffrir de troubles mentaux pour lesquels il doit recevoir des soins ou traitements t une supervision de façon continue tout en continuant à demeurer dans sa communauté. Le patient doit présenter de fortes probabilités, en raison des troubles mentaux, de causer un préjudice sérieux à lui-même ou à des tiers, ou de détérioration physique ou mentale s'il ne reçoit pas des soins ou traitements et une supervision de façon continue au sein de sa

communauté. Un programme de traitement doit être développé avec le patient avec son consentement ou celui de son représentant.

- Une formation devrait être offerte à tous les membres de la Commission de révision. Cette formation devrait inclure une introduction aux concepts et questions relatifs à la santé mentale qui pourraient être soulevés lors d'une audience en révision. La formation devrait aussi traiter des principes de justice naturelle, d'équité, de droits de la personne et des pratiques modernes de gestion des dossiers.

- Les Commissions de révision devraient fournir des motifs écrits à l'appui de leurs décisions.

- La Commission de révision ne devrait pas avoir le pouvoir d'exiger la présence physique d'un patient lors de l'audience.

- La *Loi* devrait prévoir la présence d'un conseiller en droits de la personne dans chaque établissement psychiatrique. Un conseiller en droits de la personne devrait avoir l'obligation d'expliquer une question de droits fondamentaux au meilleur de sa connaissance en répondant aux besoins spéciaux de la personne recevant ces explications. Un conseiller en droits de la personne devrait posséder les connaissances relatives au droit de faire une requête devant une Commission de révision, la nature et les procédures devant cette Commission, de même que la façon d'obtenir des services juridiques.

- Dans le cas où un établissement désirerait interdire à un patient l'accès à tout ou partie de son dossier médical, la *Loi sur les hôpitaux* devrait forcer l'établissement à déposer une requête devant la Commission de révision et au cours de l'audience, l'établissement devrait convaincre la Commission que l'interdiction d'accès au dossier médical est raisonnable.

- La divulgation d'informations médicales à toute personne devrait être permise si le détenteur du dossier médical croit raisonnablement que cette divulgation est nécessaire afin de prévenir ou d'atténuer une menace sérieuse et immédiate à la santé mentale ou physique ou à la sécurité de la personne qui est le sujet des informations médicales, d'un tiers ou de la santé publique.

- La *Loi sur les hôpitaux* devrait permettre à un patient qui possède le droit de lire son dossier médical d'exiger que des corrections y soient faites ou qu'une déclaration à l'effet qu'il est en désaccord sur certains points soit ajoutée dans le dossier.

- A des fins d'harmonisation, de clarté et d'efficacité du droit relatif à la santé mentale, les amendements à la *Loi sur les hôpitaux* devraient être apportés dans le cadre d'une loi plus large qui traiterait des questions de santé mentale. Dans le cas où l'élaboration

d'une telle loi plus large impliquerait de longs délais, les propositions de la Commission devraient alors résulter en des amendements à la *Loi sur les hôpitaux* actuelle.

AMATPIEMKEWE'L PROVISIONSL UJIT A'SPITLS ACT

SUMMARY*

1997 ek, Ministl ujit Justice aq Attorni General ujit Nopa Sko'sia elulas Law Reform Kmissnal iloqaptmilin Amatpiemkew'l Provisionsl ula A'spitl Act. A'spitl Acts-iktuk etek Nopa Sko'sia tan wen etli ankotasij, tan teli piskuwi'kuj wen a'spitl, tan koqajaltimkwe'l aq wejkuaqamimkewe'l kekkunkl tan tujiw piskuwi'kusij, tan tle'ywaten teli kpitqat, aq tan tl tua'laten.

Amatpiemkewey "Facility" teli tifine'-ewatasik Act-iktuk "A'spitl" e'wasin ujit tl jikeuksin, maliamuksin tan tujiw wen amatpiej, ula wi'katikniktuk, psychiatric disorder teli tifine-ewatasik paqs'ipki amatpien.

Piskuwikutimk Amatpiemokuomk

Mimajuinu tapunemi'k tan tel piskwa'luj amatpiemokuomk (piskwa'lsij) (voluntary) kisna kikaji piskwa'luj (Involuntary). Tlia wulte't wen piskwaluksin, miamuj malpale'wit teluet nuta'tt wula mimajuinu npiluksin. Eykk a'spitl amuj 24 hours, kulaman kisi koqaji npilaten, misoqo tewa'luj. Kikaji piskwaluj wen amatpiemokuomk, miamuj tapusiliji malpale'wiliji kisi nmi'ji aq wikatiknk waju' wika'tiji, tan tetutaskmalij ksnukowinu'l. Nesutu't ksnukowinu jileasin kisna jileywan natuenl pilue'l. Weji aja'luj ksnukowinu piluey a'spitl, kisi kikaji piskwalut se'kk. Warrant wetaqne'wasit kriminl ko't-iktuk kisna piluey tplutaqn, Judge Order-ewatoq, kisna ika'lsij pli'ssmen.

Piskwalut wen "jikeyuksin" aq msit majukwatasikl tplutaqnn A'spitl Actiktukewe'l. Mimajuin tan weji pieskwalut, ketu' kjiju't amatpa'n kisna mu amatpan. 7 (l'uiknek) nakwekl teli kpkije'ut. Ute'jkewey nakwek kaqi jike'uj, tewa'lut, kisna siawi kle'ut, ksa'tt kisna mu ksa'ttmuk. (Voluntary) wulte'tk wen siaw qatmin, kisi siaw qa'tk, malpalewit wulte'tk siaw kl'nuksilin. Apj ne'wt wen keju'jj mu koqajiek na siaw kle'ut tepknuset (l month). Tujiw na nuku minui ajatimk i'min 3 (si'st) tepknusettk (months) aq nuta'qq 6 (asukom) tepknusettk (months). Teli kpkijeut wen misoqo kaqiej Certificate, kisna malpalewit tewa'laj, kisna Supreme Kourt ujit No'pa Sko'sia, kisna A'spitley Review Board.

Teli Mpiluksin

A'spitls Act menuwekej mimajuinul iloqamuksilin tepaskmalin kisi kjijitulin tan ketu tlaluksilin nepiluj. Mentl capacity na teluemk tepi nsitue'k nsitmin tan teli ktpiej. Kisi iloqamuj mimajuin, miamuj malpalewit wajuwikik "declaration" tan teluek ula mimajuin tepaskmat nekem kisi asite'tmin nepilut. Muta a apjiw mu npisun wen iknimuaj mu minuekek, katu kikaj

*Mi'kmaw translation by: Katherine Sorbey, Listuguj, Quebec.

a npilaten mu tepi nsitueyik. Nepilut wen tlia mu wulte'tmu, aq kwilut natuen piluey tan "nestumalsewatl". "Proxy" ika'lut nujeywan aq nsitmalsewan kesnukwalitl. Mimajuin kisi nikani-pukua'lut "Advance health care directive" li'kl-ewik wikatikn tan ki's ilsut wen tan tleywaten elmiaq ika'q nakwek mu kiseasik, A'spitl Actiktuk kisi wji pukua'laten piley tan nujey watal ksnukowinul.

Ksnukowinu wtmotaqn aq wsulieweyim

Malpalewit kisi ankamisk, miamuj wikatikna'toq tan tetutaskma'n. Kiso'tmin kutmotaqn aq ksulieweyim aq tan tesik koqowey alsutmin.

Iloqaptimikl Tan kisutasikl

Ksnukowinu tli-te'tk mu koqaja'lamitip, kisi Appliewitow "Minui" iloqaptasin msit tan tesik wejiej, tan tl koqajaten koqowey. Miamuj mujka pilue'y tan mu etl lukutiliki A'spitl apoqnmakuta. Psychiatric a'spitl Review Board alsusit tan iloqaptimin tetutaskman, tan teli kpkijeulk, teli npilulk, teli maliamulk. Wujit msit askaywek Board melkapukuek aq melkapuku'tek, tan tel sutekek. Tan teli npilulk aq tele'ulk, "Review Board" pasik kisi Recommend-ewitew. Supreme Kourtiktuk ujit No'pa Sko'sia kisi iloqaptitew ksnukowinu'l tetu taskmilij, ksnukowinu kisna tan nujeatl appli'ewij ankaptasin koqowey. Tan tujiw appliewij ksnukowinu kisna nujea'tl, Supreme Kourt apj nespiw Reviewewatuaj ksnukewinul tan tetutaskamalij.

Keknue'kl Rightsimal ksnukowinu aq mimajuin tan pem jikko'tasit

A'spitl Act mesqnn wikakl rightsal ujit ksnukowinu'k aq mimajuinuk tan etli jikotasulti-jik eluwewietokuomk. Apjiw asite'lmut wen ll'mi wi'ki'kn, mataqtekewan wikma aq kisi mitukwaluksin. Mesqnn wikasik wikatikn iknmuj wen, tan eknua'taj tan qoqowey telitpiaq. Mimajuinu weskowa'sij a'spitlk iknmuj apoqnmasuti tan tujiw kwelmaj lo'eral aq tan tli appliewitew ujit Review. Kiaskew a'spitlk-ewaq kelo'tmitij ksnukewinu'l tan tele'lij. Awisiw wen piluey nemitoql wikatiknn tan ksnukowinu wetmintetaqnim.

Preliminary Suggestions ujit koqajataqn

Kmisn elitasualaji mimajuinu ujit apoqnmasuti tan tl lukwataq wetnukwatmikkl ujit koqajatasin eluwewiemkewe'l provisionsl A'spitl Act-te'l.

- "Psychiatric disorder" mina'tunes, awnaqa e'wasis "mental disorder." Mental Disorder tli tifine'ewa'tasis a maminu awnasita'sin, milo'teken, tan teli usua'tu'n koqowey, n'tu'n mikwitetaqanim, kaqi'ssmilqamiksin, keska'n aq kitnman. Kmisn kwelk me ap piluey koqowey me' tan kisi wi'tasis tan ankua'tus definition ujit Mental Disorder.

- Nopa Sko'sia lejisle'sn tepawtiss asite'tmin ki'kaji piskwaluskin wen amatpiej (mental disorder) mu pasik wen ketu askayasij kisna pilue'l ketu askaywaj, aq elp nespiw maminu muskuaja'teken.

- Kaqi iloqamanes wen tetutaskmaj 24 hours, aq siaw kleywaness 48 hours nuta'qq.

- Tan tujiw pli'ss officer kisna wen piluey pekisulaj ksnukewinul a'spitl piskuwikusiss aq te'u wikusiss ktu majasij.

- A'spitlewaq kinua'tuatiss pli'ss officeral tan tujiw kaqi iloqamatij ksnukewinul aq mu tepi ksnukwalikwul siaw kle'walno.

- Declaration ujit piskwaltimk tl'tess kisi minua'tmk tepknuset (1 month), ap nuta'q tapusijik tepknusetk (2 months), na nuku tes nutaq ap ne'sijik tepknusetk (3 months). Apj me anku nutaq ap nuku tes sistewey tepknuset ika'j na minua'tn wikatiknn.

- A'spitl Actiktuk tlte'ss kes mu ksnukowinu npiluksin, miamuj welte'tkiss npiluksin. Wula tl meanewiss ksnukewinu kejitoqip tan ketu tli npiluj. Tan npisun tlalukutew, tan telamu'k nsanoqn eliej, aq etukjel ap natukoqowey piluey wtnu'kwatimwaten, aq tan tlit-pietew mu npissik.

- Mimajiun tli wsua'laness koqajatpan, misoqo muskatoq mu koqajiek, mu tli wsua'luksin eluwe'wiet muta eykk eluwe'wietokuomk.

- Ankua'luksin wnje-e'k malpale'witk (psychiatrists), ktikikk tan pema'tutij kinamasuti asite'lmaness siawatunew tan tetutaskmalij ksnukowinu'k.

- Tplutaqniktuk wtitaqnewasis kisi namkem npiluksin ksnukowinu, tan tujiw amsami wisqasik teli ksnukwaj.

- E'mitukwemewe'l wikatiknn iknemuetuness Nopa Sko'sia ujit eykik ksnukewinu'k. Miamuj ksnukowinu tepi nutaj klo'tasin aq jikeyuksin elmiej we'kaw mesnik e'mitukwemkewe'l wikatiknn aq nsanoqonit newtukwa'lukwej. Mawu'timiness tan tl apoqnmuanes, aq tan wulte'ss ksnukowinu.

- Kinu'timuanes tanik Review Board naspultijik. Kinamuanes tan telitpiaq koqowey assukweteskitaq tan tujiw hearing-ik Review Board. Kinamuanes nespiw natural justice, fairness (tetpaltimk), human right-sey tplutaqn, aq me' mu tli pukweltnuj ne'wsinuk elukwatmi'tij.

- Review Board-tl msaqn-wi'kimi'tiss tan koqowey ujit wet tlsutaqatitij.

- Review Board-tl mu tl mamuni-kna'nus we'kaw miamuj i'milin ksnukowinul tan tujiw hearing-ik.

- Act tepawtiss ikalan rights adviser-al e'tasiw a'spitl ujit mimajuinu tan awnasatpiet. Rights Adviser nuji knua'tuas ksnukowinu Right-timual tan apoqnmuas wuli nsitakun. Rights Adviser wula'siss wuli nsitmin tan tel taqnewasik. Apply-ewin review board aqq tan tli msntess li'kl service-sl.

- A'spitl mu asite'lmaq ksnukewinul nmian wt-recortimk, na a'spitls act kwiluts review board hearing, aq amuj a'spitl sapa'muas board-al taqowey ujit wjiwuliatew mu nmituk wen recordeml.

- Kisi nmitus mimajuinu tan tel wa'qajekip mesqnwikasik, tan kis tla'luj, tepi telmaj tan nujo'tkl wikatiknn.

- A'spitls act asite'lmas ksnukowinul ankaptmin tan wejiej, aq tan mu welaptimilik iljoatasin aq wiaqatasin tan teleuj wikatikniktuk.

- Ktumoqjekmin tan wije'tultik aq koqaja'sik mental health law, a'spitls act nuta'q sa'sewa tasitn wije'wmin tplutaqn tan iljo'qnk msit mental health tel pmiaq. Kisi ila'timk me mu teli kpkiji skmawun, na kmisn's propo'sl awnaqa iljoatus a'spitls act.

I INTRODUCTION

1. The project

By letter dated December 18, 1997, the Minister of Justice and Attorney General formally referred the study of mental health law reform to the Law Reform Commission. The Minister stated:

> *Upon request of the Minister of Health, and pursuant to section 8(2) of the* Law Reform Commission Act, *S.N.S. 1990, c. 17, I refer to the Law Reform Commission for its review and advice the mental health provisions of the* Hospitals Act, *R.S. 1989, c. 208, to be dealt with in the usual course.*

The mental health provisions of the *Hospitals Act* govern psychiatric facilities in Nova Scotia, and in particular, how people are admitted to psychiatric facilities, what rights and entitlements they have on admission, the conditions of their stay, and how they are discharged.

To help identify relevant issues, in June 1999, the Commission formed an Advisory Group, consisting of people with particular knowledge or concerns relating to mental health law. The Advisory Group included representatives from Government, mental health organizations, including consumer groups, health care professionals, the aboriginal community, universities, and law enforcement. The group met throughout June, July, September, and October 1999. The Commission is grateful for the contributions of the Advisory Group members.

A Final Report to the Minister of Justice and Attorney General will be prepared after the Commission has taken into account public comments received on this Paper and its suggestions for reform.

2. Definitions

This Discussion Paper attempts to present legal information as clearly as possible so that people who do not have legal training can understand and comment on the Commission's suggestions for reform. As some of the language relates to specific legal and technical concepts, the words used may not be familiar to everyone. This section provides definitions of such words used in this Paper.

Act - Law made by elected members of government. Also referred to as "statute" or "legislation."

Action - Court proceeding by which a person makes a claim or asserts a right.

Admission certificate	-	Written authority to admit a person as an involuntary patient. Also referred to as "declaration of formal admission."
Advance health care directive	-	A legal document in which a person sets out how his or her health care is to be managed in the event of mental incapacity. The document may appoint a representative, known as a "substitute decision-maker" or "proxy," to make health care decisions, may set out general principles or specific instructions about how a person's health care is to be managed, or may do both.
Advocate	-	Individual who provides support and speaks for another.
Appeal	-	A proceeding to set aside or vary a decision which has been made by another court, tribunal or individual.
Civil commitment	-	Compulsory admission of a person as a patient to a psychiatric facility.
Common law	-	Law developed over the years by judges when making decisions in court. These decisions are relied upon by other judges in making decisions in later cases.
Community treatment order	-	A legal mechanism which provides for the involuntary treatment of a patient who lives in the community, subject to a number of conditions and restrictions.
Declaration of formal admission	-	Written authority to admit a person as an involuntary patient. Also referred to as "admission certificate."
Estate	-	Everything that a person owns.
Formal patient	-	Person whose admission as a patient to a psychiatric facility is compulsory. Also known as "involuntary patient." The process by which one becomes a formal patient is sometimes known as "civil commitment."
Guardian	-	An individual with the rights and duty of protecting the person, property, or rights of someone who is not mentally capable or is otherwise unable to manage his or her own affairs.

Indictable offence	-	Generally a more serious criminal offence. An indictment is an accusation in writing of an offence.
Informal patient	-	Person whose admission as a patient to a psychiatric facility is non-compulsory. Also known as "voluntary patient."
Involuntary patient	-	Person whose admission to a psychiatric facility is compulsory. Also known as "formal patient." The process whereby one becomes an involuntary patient is sometimes known as "civil commitment."
In-patient services	-	Services provided within a hospital setting in which a patient stays 24 hours a day, in order to receive medical and nursing attention.
Leave certificate	-	Similar to "community treatment order," a mechanism to allow involuntary patients to return to the community and receive treatment there, but with the consent of a patient or of a patient's representative.
Legislation	-	Law made by elected members of government. Also referred to as "statute" or "act."
Mental capacity	-	An individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors.
Mental health consumer	-	A person who, because of a mental health problem, uses or at some point used, mental health services.
Mental illness or disorder	-	A severe mental health problem usually associated with impaired functioning due to a biological, chemical, genetic, physical, psychological, or social disturbance.
Parens patriae	-	Literally "parent of the country" - exclusive jurisdiction of the sovereign over those people perceived unable to manage their own affairs.
Patient	-	Person admitted to a psychiatric facility for diagnosis, lodging, or treatment. A patient can be "voluntary," also known as "informal," or can be "involuntary," also known as "formal."
Person under observation	-	Person admitted to a psychiatric facility for the purpose of an examination and psychiatric assessment.

Proxy	-	Person appointed to make health care decisions on behalf of someone else. Also known as "substitute decision-maker."
Psychiatric assessment	-	Determination of the presence or absence of a mental illness or disorder.
Psychiatric facility	-	A hospital or part thereof used for the observation, care and treatment of people with mental illness.
Psychiatrist	-	A physician with special training in psychiatry, a body of knowledge associated with the diagnosis and treatment of mental illness.
Public Trustee	-	A government office that may be appointed to, among other matters, act as guardian of an adult who is found unable to manage his or her own affairs.
Records	-	Information files kept by individuals, programs and services to document their work with people.
Renewal certificate	-	Authority to extend a person's "involuntary" or "formal" patient status beyond the duration of the original "admission certificate" or the most recent renewal certificate.
Review	-	To reconsider a decision.
Search warrant	-	An order, issued by a judge or justice of the peace, authorizing a named person to enter a certain place to search for and seize particular property which will provide evidence of the intended or actual commission of a crime.
Substitute decision-maker	-	Person appointed to make health care decisions on behalf of someone else. Also known as "proxy."
Statute	-	Law made by elected members of government. Also referred to as "legislation" or "act."
Tribunal	-	Body or person exercising a statutory decision-making power outside the regular court system.
Voluntary patient	-	Person whose admission as a patient to a psychiatric facility is non-compulsory. Also known as "informal patient."

II GENERAL INFORMATION

A. DEVELOPMENT OF CIVIL COMMITMENT LAW

1. Role of the state

The role of the state in taking custody and care of people with mental illness is a long-standing one. In Nova Scotia, the relevant law has its source in an ancient concept, *parens patriae*, which literally means "parent of the country."[1] This concept originated in the law of England at least as long ago as the 13th century.[2] As the highest authority in the land, the sovereign was seen as the natural choice to take care of those people, such as the mentally ill, who were perceived unable to manage their own affairs. The concept was "founded on the obvious necessity that the law should place somewhere the care of persons who are not able to take care of themselves."[3] Otherwise, it was feared, people with mental illness might do injury to themselves or squander their fortunes.[4] *Parens patriae* formed part of the "royal prerogative," a group of rights and capacities enjoyed only by the sovereign.[5] *Parens patriae* gave the sovereign an exclusive jurisdiction over people with mental illness and their property. This jurisdiction was not actually exercised by the sovereign in person, but was delegated to the Lord Chancellor, who was the head of the Court of Chancery.[6]

Mentally disabled people subject to *parens patriae* were traditionally described by the law as either "idiots" or "lunatics."[7] Both were seen as incapable of managing their own interests. An idiot was considered mentally disabled from the time of birth, while a lunatic was someone who developed a mental illness during the course of his or her lifetime.[8]

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[1] J.R. Nolan & M.J. Connolly, *Black's Law Dictionary*, 5th ed. (St. Paul, Minn.: West Publishing, 1979) [hereinafter *Black's Law Dictionary*] at 1003.

[2] G.B. Robertson, *Mental Disability and the Law in Canada*, 2nd ed. (Scarborough, Ont.: Carswell, 1994) at 8.

[3] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 28 (S.C.C.).

[4] B. Murdoch, *Epitome of the Laws of Nova-Scotia*, vol.1 (Halifax: Joseph Howe, 1832-33) at 118.

[5] *Black's Law Dictionary*, note 1, above, at 1195.

[6] *Re Bulger* (1911), 1 W.W.R. 248 at 249 (Man. K.B.). Later on, the jurisdiction was delegated to two Chancery Court judges: Robertson, note 2, above, at 8.

[7] In its reports, the Commission attempts to use language which is respectful and inclusive. In discussing earlier legal concepts, however, it is sometimes necessary to mention terms now considered insensitive or demeaning.

[8] Murdoch, note 4, above, at 118-119.

In Nova Scotia, a Court of Chancery was created by royal authority in 1749.[9] As, however, there was no Lord Chancellor in Nova Scotia, the Governor was chosen to serve as head of the court.[10] The Governor also assumed the royal jurisdiction over people with mental illness.[11] In *R.* v. *Martin*, an 1854 decision, Halliburton, C. J. confirmed the application of *parens patriae* in Nova Scotia: "The Crown as the *parens patriae* is entitled, by its inherent prerogative, to the custody of all insane persons, for the purpose of protecting the community."[12]

2. Statutory approaches

Gradually, the *parens patriae* jurisdiction, which was part of the common law, took the form of statutes created by the Legislature. This part of the Paper summarizes some of the more significant aspects of those earlier statutes, which have contributed to the development of current legislation concerning psychiatric facilities in Nova Scotia.

In 1759, the Nova Scotia House of Assembly enacted a statute to provide for the establishment of a house of correction or workhouse in Halifax.[13] This institution, commonly referred to as a "bridewell," served as a jail, a reformatory, and place of commitment for people seen as socially undesirable.[14] It was meant not only for pre-trial detention, but also for long-term confinement and punishment, and in particular, hard labour. The groups of people liable to be confined there were varied, including the poor, minor criminals, and people with mental illness.[15] The workhouse was notorious for its cold, damp, and unhealthy conditions.[16]

From early days in Nova Scotia, therefore, people with mental illness were treated as a social problem. The emphasis in dealing with this problem was on confinement. This was apparent in a 1774 statute titled, *An Act for Punishing Rogues, Vagabonds, and Other Idle and*

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[9] C.J. Townshend, *History of the Court of Chancery in Nova Scotia* (Toronto: Carswell, 1900) at 63.

[10] B. Cahill, "*Bleak House* Revisited: The Records and Papers of the Court of Chancery of Nova Scotia, 1751-1855" (1989-90) 29 Archivaria 149 at 150.

[11] Murdoch, note 4, above, vol. 4, at 44.

[12] (1854), 2 N.S.R. 322 at 324 (N.S.C.A.) The sovereign's jurisdiction over people with mental illness was also mentioned by statute: S.N.S. 1774, c. 5, s. 8.

[13] S.N.S. 1759, c. 1.

[14] R. Baehre, "From Bridewell to Federal Penitentiary: Prisons and Punishment in Nova Scotia Before 1880," in P. Girard and J. Phillips, eds., *Essays in the History of Canada Law*, vol. 3, *Nova Scotia* (Toronto: University of Toronto Press, 1990) 163 at 166.

[15] Note 13, above, ss. 2, 5.

[16] Baehre, note 14, above, at 167.

Disorderly Persons.[17] This statute, based on British legislation,[18] set out a procedure for apprehending and confining people with mental illness. Where persons were considered to be "furiously mad, and dangerous to be permitted to go abroad," two justices of the peace could order them to "be apprehended, and kept safely locked up in some secure place within the county."[19] The justices also had the power to order that such people be kept chained. Given this reference to dangerousness, the law signalled that it was no longer concerned solely with protecting mentally ill people, but also considered it necessary to protect the community from potential harm by certain people with mental illness. Although the applicable period of restraint was "such time only as such madness continue[d]," no details were provided about the release of anyone confined in accordance with the statute. Section 8 of the 1774 statute did, however, offer an alternative to confinement, by allowing friends or relatives to take under their care those mentally ill persons who would otherwise have been confined.

In 1792, the House of Assembly provided for the establishment of workhouses outside of Halifax.[20] Separate buildings were not deemed necessary, as a portion of the local jail could be used instead. At the Halifax workhouse, depending on the period in question, a separate building, or an annex to the main building, was sometimes used for people with mental illness; at other times, all residents were housed together.[21] In 1832, a committee from the Nova Scotia House of Assembly visited the Halifax facility. The committee was appalled by the crowded and disease-ridden conditions.[22]

In 1851, the legislature passed the statute, *Of Madmen and Vagrants*.[23] For the most part, this statute retained the features of the 1774 *Act*. The 1851 statute contained no reference, however, to people with mental illness being considered "dangerous." Rather, the statute provided that a "madman" was to be "secured" in his or her legal settlement. Unlike the 1774 *Act*, the 1851 statute did not refer to the duration of a person's confinement. Implicitly,

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[17] S.N.S. 1774, c. 5.

[18] M. Kingma, *Mental Health Law: A Critique of the 'Dangerousness' Criterion for Civil Commitment and Some Recommendations for Change* (LL.M. Thesis, Dalhousie University, 1995) [unpublished] at 145.

[19] Note 17, above, s. 7.

[20] S.N.S. 1792, c. 5.

[21] A.H. MacDonald, *Mount Hope Then and Now: A History of the Nova Scotia Hospital* ([Dartmouth, N.S.]: The Nova Scotia Hospital, 1996) at 14.

[22] The committee also noted that different categories of residents were not kept apart. See Nova Scotia, *Journal and Proceedings of the House of Assembly* [hereinafter J.H.A.] (1832), App. 49. After a visit in 1845, Assembly members similarly reported overcrowding: J.H.A. (1845), App. 70 at 200.

[23] R.S.N.S. 1851, c. 104.

therefore, the detention of people with mental disorders could be indefinite. Detainees could still be chained.

Until the mid-19th century, there was little change in the state's approach in Nova Scotia to people with mental illness. Statutes emphasized confinement, which tended to take place under deplorable conditions. There was no reference in the legislation to the treatment of people with mental illness, let alone to any rights they might have.

Soon after the passage of 1851 statute, however, Nova Scotia legislators turned their attention to more appropriate housing and even treatment for people with mental illness.[24] For a number of years, there had been calls from varied interests, including the Medical Society, the Board of Health, newspapers, individual physicians, and concerned citizens, for the establishment of an institution devoted exclusively to the care and treatment of people with mental illness.[25] A former insistence on the "mere safe custody" of people with mental illness was replaced by confidence in the treatability of mental illness, especially if treatment was undertaken early.[26] In the words of a committee report, presented to the House of Assembly in 1845, "[c]orporeal punishment, confinement and chains, [were] no longer considered indispensable - these [had] given way to the vigilant eye of a well qualified attendant."[27] Legislators became aware of developments outside Nova Scotia, particularly in the United States, involving the treatment of people with mental illness. The concept of an asylum, meant specifically for the care and treatment of people with mental illness, had developed. With asylums seemingly "sanctioned by the example of every civilized State,"[28] there was a belief that Nova Scotia should not be left behind.

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[24] Also in 1851, the Nova Scotia legislature added another facet to the law relating to people with mental illness, with the passage of the Act, *Of the Custody and Estates of Lunatics*, R.S.N.S. 1851, c. 152. It provided for the guardianship of people with mental illness and care of their property. It did not, however, involve confinement.

[25] C.E. Saunders, *Social Conditions and Legislation in Nova Scotia (1815-1851)* (M.A. Thesis, Dalhousie University, 1949) [unpublished] at 155, 163-164; D. Francis, "The Development of the Lunatic Asylum in the Maritime Provinces" (1977) 6:2 Acadiensis 23 at 28.

[26] J.H.A. (1845), App. 70 at 201.

[27] Note 26, above.

[28] J.H.A. (1846), App. 32 at 105. See also J.H.A. (1850), App. 18. Asylums, which attempted to treat people with mental illness, rather than simply serve as custodial housing, were first established in North America in the 1830s: G. Andrews, *The Establishment of Institutional Care in Halifax in the Mid-Nineteenth Century* (Honours Essay, Dalhousie University, 1974) [unpublished] at 18.

In 1852, a statute was enacted to provide for the founding of a provincial "lunatic asylum," designed to be a "building fitted for the reception and proper keeping of lunatics and idiots."[29] In 1858, another statute indicated that this institution, to be called the Provincial Hospital for the Insane, would provide "the most humane and enlightened curative treatment of the insane of this province."[30] Preference in admission was for those cases "of most recent occurrence, and hence most likely to be benefitted by hospital treatment."[31] The Provincial Hospital received its first patient at the end of 1858.[32] As the 19th century unfolded, the Provincial Hospital tended to be overcrowded, with neither sufficient staff, nor adequate facilities, to deal with the numbers of patients.[33]

According to an 1858 statute, if an application concerning an "insane person" was made to any two justices of the peace, it was their duty to investigate that person's "insanity" and to commit that person to the county jail, if satisfied "that such person [was], by reason of insanity, unsafe to be at large, or [was] suffering any unnecessary duress or hardship."[34] To determine whether a person was "insane" the justices could rely on the assistance of physicians, though this was not necessary.[35] After being committed to the county jail, a person with a mental illness could be transferred to the provincial hospital. Two medical certificates were required for admission. These certificates had to be signed by two physicians, who stated that "they [had] personally and separately examined such patient, and believe[d] him or her to be insane."[36]

A statute enacted in 1872 renamed the provincial psychiatric facility the Nova Scotia Hospital for the Insane.[37] Patients who had been under care for more than six months in the hospital, and who had recovered far enough to enable them to be taken care of in a private family

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[29] S.N.S. 1852, c. 13, s. 2.

[30] S.N.S. 1858, c. 38, s. 1.

[31] Note 30, above, s. 15. See also s. 12 of the same statute.

[32] J.H.A. (1859), App. 10 at 162.

[33] MacDonald, note 21, above, at 56, 78; Francis, note 25, above, at 34.

[34] Note 30, above, s. 14.

[35] Note 30, above, s. 14; S.N.S. 1855, c. 34, s. 3.

[36] Note 30, above, s. 20.

[37] S.N.S. 1872, c . ss. 20, 25.

setting, could be discharged on a trial basis into the care of relatives or friends, or could be placed as boarders.[38]

In 1886, the province provided for the establishment of asylums outside Halifax for people with mental illness. These institutions were meant "for the care of the harmless insane, idiotic persons, and epileptic persons who [were] insane but who [had] not manifested symptoms of violent insanity."[39] The county asylum system was not intended to provide treatment.[40] People with mental illness and other groups of people confined there were not necessarily kept apart, as the buildings could be used both as poorhouses and as "lunatic asylums."[41]

In 1900, the name of the provincial psychiatric facility was changed to the Nova Scotia Hospital.[42] In 1909, medical certificates were explicitly made sufficient authority for any person to convey a patient to the provincial hospital and for the medical superintendent at the hospital to detain the patient therein for treatment, until discharged.[43]

The concept of "voluntary patients" was made part of Nova Scotia law in 1912. There was a possibility for voluntary admission of a person to the Nova Scotia Hospital, so long as the person applied in writing, the medical superintendent recommended that person's admission, and there was an order from the Government minister in charge. After they had given written notice of an intention to leave the hospital, voluntary patients were not to be detained more than three days.[44]

In 1944, the police were identified as one of the groups empowered to apprehend and return without warrant any people who left without permission from a local asylum.[45]

In 1960, six procedures were set out for the admission of a patient to the Nova Scotia Hospital: voluntary; by medical certificate; by transfer from a municipal psychiatric facility; by magistrate's order; by virtue of the *Criminal Code*, or certain other federal statutes; or by

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[38] Note 37, above, s. 32.

[39] S.N.S. 1886, c. 44, s. 1.

[40] Nova Scotia, *Report of the Royal Commission on the Halifax County Hospital* ([Kentville, N.S.: Ministry of Public Health], 1970) (Commissioner: H.P. MacKeen) at 15.

[41] Note 39, above, s. 15.

[42] R.S.N.S. 1900, c. 44, s. 1.

[43] S.N.S. 1909, c. 17, ss. 2, 4.

[44] S.N.S. 1912, c. 31, s. 1.

[45] S.N.S. 1944, c. 19, s. 1.

transfer from a mental hospital in another province or state or from a hospital under federal jurisdiction.[46]

The 1960 statute also provided for the appeal of a decision concerning a patient, on the ground that he or she was "not mentally ill."[47] Patients did not then enjoy this right. Rather, the right to appeal was provided to a relative or a friend of the patient, or to an interested party. In 1967, patients received the right to apply to a court for discharge from the Nova Scotia Hospital.[48] Prior to these provisions, there had been little consideration in Nova Scotia statutes to establishing procedural safeguards to protect the rights of people with mental illness.

Under the 1967 statute, a patient's admission to the Nova Scotia Hospital could last a year and was renewable. Those patients who were considered to have recovered enough to return to the community could benefit from a trial release of up to six months.

The *Hospitals Act* is the current statute which governs psychiatric facilities in Nova Scotia, and in particular, the admission of patients, their rights while at a facility, the conditions of their stay, and how they are discharged. It was enacted in 1977,[49] came into force in 1979,[50] and is now part of the Revised Statutes of Nova Scotia.[51]

B. THE CURRENT LAW

1. The *Hospitals Act*

The *Hospitals Act* is legislation which in part governs the admission, either on a voluntary or involuntary basis, of people to psychiatric facilities in Nova Scotia. A facility is defined in the *Act* as a hospital or part of a hospital "used for the observation, care and treatment of persons suffering from psychiatric disorder."[52] A psychiatric disorder is a severe mental health problem usually associated with impaired functioning due to a biological, chemical, genetic,

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[46] S.N.S. 1960, c. 8, s. 12(3).

[47] Note 46, above, s. 25(1).

[48] S.N.S. 1967, c. 15, s. 28.

[49] S.N.S. 1977, c. 45. For a discussion of the motivation which may have led to the current statute, see L.E. Rozovsky, "New Developments in Nova Scotia Psychiatric Legislation" (1979) 5 Dalhousie L.J. 505.

[50] O.I.C. 79-12, N.S. Gaz. 1979.II.7.

[51] R.S.N.S. 1989, c. 208.

[52] Note 51, above, s. 2(d).

physical, psychological, or social disturbance.[53] Unless referring to specific statutory language, the Discussion Paper uses the term "mental illness" or "mental disorder" rather than psychiatric disorder or equivalent terms. The *Hospitals Act* also sets out guidelines concerning the assessment, treatment and discharge from psychiatric facilities of people with mental illness. This part of the Paper summarizes how people in Nova Scotia are admitted to psychiatric facilities, what rights and entitlements they have on admission, and the conditions of their stay.

2. Admission to a psychiatric facility

A person can be admitted to a psychiatric facility in two ways:

a) With consent - voluntary admission:[54]

For a person to be admitted voluntarily to a psychiatric facility, his or her consent is required. A qualified physician must also indicate that the person requires the "in-patient" services provided by the facility.[55] An in-patient is a patient who remains at a facility 24 hours a day, in order to receive medical and nursing attention, until discharged.

b) Without consent - involuntary admission:[56]

i) **Medical certificates** - The involuntary admission of a person to a psychiatric facility can take place on the basis of two medical certificates issued by physicians, each of whom has examined the person. The medical certificates must state that the physician has reasonable and probable grounds to believe that the person suffers from a "psychiatric disorder," and that the person should be admitted because he or she needs in-patient services and requires care that cannot be adequately provided outside the facility, because he or she is a danger to his or her own safety or the safety of others.[57]

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[53] Nova Scotia, Mental Health Review Provincial Committee, *A New Step Forward: Improving Mental Health Services for Children and Youth in Nova Scotia* ([Halifax]: Departments of Health and Community Services, 1998) [hereinafter *A New Step Forward*] at 42, 44.

[54] The *Hospitals Act* refers to voluntary admission as "informal admission." In this Paper, the term "voluntary admission" is used instead, as it is more descriptive and its meaning more clear.

[55] Note 51, above, s. 34(4).

[56] Although the *Hospitals Act* uses the term "formal admission," in this Paper, the term "involuntary admission" is used instead.

[57] Note 51, above, s. 36. A "psychiatric disorder" is defined at s. 2(q) of the *Act* to mean "any disease or disability of the mind [including] alcoholism and drug addiction."

ii) **Transfer** - A person may be transferred from another psychiatric facility within the province or a person may be transferred to a facility from another facility outside of Nova Scotia.[58]

iii) **Warrant or order** - The *Criminal Code* or another federal or provincial statute may provide grounds for a person's involuntary admission.[59]

iv) **Judicial order** - Section 37 of the *Hospitals Act* provides that a person may be involuntarily admitted to a facility pursuant to a Provincial Court judge's order directing an examination.

v) **Apprehension by a peace officer** - Where there are reasonable and probable grounds for a peace officer to believe a person suffers from a psychiatric disorder and is either dangerous or is about to commit an indictable offence, the peace officer may take that person to an appropriate place, for a medical examination.[60]

3. Status on admission to a facility

A person is admitted as a "person for observation" with respect to most routes of entry under the *Hospitals Act*.[61] A person under observation is admitted to a facility for the purpose of an examination and psychiatric assessment. A psychiatric assessment involves the determination of the presence or absence of a mental illness or disorder.[62] Every person under observation must be examined by a physician and a psychiatrist within 24 hours and three days, respectively, of admission to the facility. A person may remain under observation for up to seven days. During the observation period, a person who is admitted for observation other

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[58] Note 51, above, s. 35(1).

[59] Note 51, above, s. 35(2).

[60] An indictable offence is generally a more serious criminal offence. An indictment is an accusation in writing of an offence: J.A. Yogis, *Canadian Law Dictionary* (Hauppauge, N.Y.: Barron's, 1998) at 128. This Paper does not specifically address issues concerning admission to psychiatric facilities under the criminal law, which is a matter of federal government jurisdiction. For an introduction, see instead Robertson, note 2, above, at 434-437.

[61] Note 51, above, s. 34(1).

[62] *A New Step Forward*, note 53, above, at 35.

than with his or her consent may be detained in a facility[63] and returned there if the person is absent without authorization.[64]

After the expiry of the seven day observation period, the person may be discharged, or the person may remain in a facility as a voluntary or involuntary patient.[65] A voluntary patient remains in a facility as long as the patient consents and a physician recommends the patient's continued admission.[66] The *Hospitals Act* refers to a voluntary patient as an "informal patient."

A person declared to be an involuntary patient must remain in the facility.[67] Under the *Hospitals Act*, an involuntary patient is known as a "formal patient." A person admitted as an involuntary patient is sometimes said to have been "committed" to a facility, with the involuntary admission process referred to as civil commitment. Once declared an involuntary patient, a person may be detained in a facility for an initial detention period which can last up to one month.[68] A declaration of involuntary admission may be renewed to extend the period of detention for two successive three month periods and thereafter for six month periods.[69] The detention of a patient under an involuntary admission certificate lasts, subject to statutory time limits, until the patient is discharged by a psychiatrist,[70] the Supreme Court,[71] or the Psychiatric Facilities Review Board.[72]

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[63] Note 51, above, s. 44(4).

[64] Note 51, above, s. 46.

[65] Note 51, above, s. 34(3).

[66] Note 51, above, s. 34(4).

[67] Note 51, above, ss. 34(5) and 46.

[68] Note 51, above, s. 44(2).

[69] Note 51, above, s. 44(3).

[70] Note 51, above, s. 45(2).

[71] Note 51, above, s. 47. S. 47 actually refers to the County Court, which has been abolished. Matters formerly heard by the County Court are now, however, heard by the Supreme Court: *An Act to Reform the Courts of the Province*, S.N.S. 1992, c. 16, ss. 1, 5.

[72] Note 51, above, s. 63(a).

4. Decisions made during a person's hospitalization

a) Treatment

Section 51 of the *Hospitals Act* requires a person to be examined within three days of admission to a facility in order to have determined his or her capacity to consent to treatment.[73] The examination is done by a psychiatrist. In making this determination, a psychiatrist must consider:[74]

i) the person's understanding of the condition for which the treatment is proposed;
ii) the person's understanding of the nature and purpose of the treatment;
iii) the person's understanding of the risks of the treatment;
iv) the person's understanding of the risks in not undergoing the treatment; and
v) the person's condition and the effects of the condition on his or her ability to consent.

After the examination, the psychiatrist must complete a "declaration," which states whether in the psychiatrist's opinion the person examined is capable of consent to treatment.[75]

In general, no treatment may be administered without consent unless the person does not have the capacity to consent. Treatment can, however, proceed even in the face of a refusal if the person is deemed incapable of consenting to the treatment, and if consent of a "substitute decision-maker" is obtained.[76] A substitute decision-maker or "proxy" is a person appointed to make health care decisions on behalf of someone else.

b) Property

Competency to administer one's financial affairs is also decided by a psychiatrist, who must consider:[77]

i) the nature and degree of the person's condition;
ii) the complexity of the person's estate;

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[73] Mental capacity is an individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors: *A New Step Forward*, note 53, above, at 36.

[74] Note 51, above, s. 52(2).

[75] Note 51, above, s. 53.

[76] Note 51, above, s. 54.

[77] Note 51, above, s. 52(3). The *Hospitals Act* does not specify when a determination of a person's competency to handle his or her own financial matters is to be completed.

iii) the effect of the condition upon the person's conduct in looking after his or her estate; and

iv) any other circumstances the psychiatrist considers relevant to the estate, the person and his or her condition.

Similar to a capacity declaration, upon completion of an examination, the psychiatrist must provide a declaration concerning the examined person's competency to administer his or her estate.[78]

5. Review decisions under the *Hospitals Act*

a) Psychiatric Facilities Review Board

Certain decisions concerning a patient in a facility are not necessarily final. Rather, if a patient believes that a decision was wrong or unfair, he or she can apply to have the decision "reviewed" or reconsidered, by a decision-maker external to the facility. The Psychiatric Facilities Review Board has the authority to review declarations involving capacity or competency, as well as issues involving detention, treatment, or care. For all issues, with the exception of treatment or care, the board has the power to make a binding order. For treatment or care, the review board can only make recommendations.[79]

The review board must review the file of a patient when requested by the patient, a person authorized by the patient, the administrator or medical director of the facility where the person is a patient, the administrator of psychiatric mental health services, or the Minister, within one month of the request. A review board may, however, refuse to review a patient's file where it has been reviewed within the previous six months.[80] An involuntary patient's file must be reviewed every six months during the first two years of admission and every twelve months thereafter. However, a review board is also able to review the file of any patient at any time.[81]

Section 66 of the *Hospitals Act* provides a patient or the patient's representative with the right to attend a review hearing involving that patient. The right to attend includes the right to be heard. Within 14 days of a review board hearing, the review board must forward a written

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[78] Note 51, above, s. 53.

[79] Note 51, above, s. 63.

[80] Note 51, above, s. 65.

[81] Note 51, above, s. 64.

decision to the person who requested the review, the patient or the patient's representative, the facility administrator and the administrator of psychiatric mental health services.[82]

b) Nova Scotia Supreme Court

Section 47 of the *Hospitals Act* enables the Supreme Court to review an involuntary patient's status upon application by the patient or his or her representative (guardian, spouse, next of kin, Public Trustee). Upon application by the patient or the patient's representative, the Supreme Court may also review declarations of capacity or competency.[83]

6. Specific rights under the *Hospitals Act*

Section 70 of the *Hospitals Act* provides certain rights for patients and persons under observation at a psychiatric facility. Generally, a person will be able to communicate freely by mail, including reasonable access to letter writing materials. A person will be able to make unmonitored telephone calls except where this would be detrimental to the person or to others. A person will also be permitted to receive visitors. Written advice is to be provided to a person regarding letters, telephone use, visits, legal representation, file review, and review of capacity or competency declarations. A person in a facility is to be given assistance in understanding any document, in contacting a lawyer, and in applying for a review. In addition, the confidentiality of health information, relating to persons presently or formerly in a hospital, is largely protected at section 71.

7. Effect of the *Charter*

The *Canadian Charter of Rights and Freedoms*[84] is the supreme law of Canada. Every provincial and federal law must comply with it. If a court determines that a provincial or federal law infringes a right or freedom expressed in the *Charter*, that law may be found to be invalid and therefore of no effect.

A number of *Charter* sections are relevant in the context of civil commitment. Under section 7 of the *Charter*, an individual cannot be deprived of life, liberty or security of the person unless that deprivation is consistent with the principles of fundamental justice. Section 9 guarantees a person the right not to be arbitrarily detained or imprisoned. According to section 10, every person has the right on arrest or detention to be informed promptly of the reasons therefor, as well as the right to retain and instruct a lawyer without delay and to be

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[82] Note 51, above, s. 67.

[83] Note 51, above, s. 58(2).

[84] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, (U.K.), 1982, c.11 [hereinafter the *Charter*].

informed of that right. Section 12 states that a person has the right not be subjected to cruel and unusual treatment or punishment. Under section 15, every person is equal before and under the law and has the right not be discriminated against on the basis of a number of factors, including mental disability.

Charter rights are not absolute. Rather, in accordance with section 1, they are subject to limits. Section 1 requires any limits that are placed on a person's *Charter* rights to be "reasonable and justifiable in a free and democratic society."

8. Competing values

There are strongly held and often conflicting values involved in any discussion of mental health law. Canadian society places a high value on individual freedom, including self-determination, being able to take an active role, without interference, in deciding one's future. Part of self-determination involves choosing what, if any, medical treatment one is prepared to undergo. Individual freedom, however, is not absolute. For instance, limits may be placed on individual freedom when it would otherwise infringe the freedoms of other people. Individual freedom may conflict with another important value of Canadian society, that people should be free from danger at the hands of others. In the context of mental health law, it is also sometimes suggested there is a social responsibility to provide treatment to those individuals, who may not, as a result of mental illness, be able to recognize their need for treatment. In preparing this Discussion Paper, the Commission has attempted to balance such values as the maintenance of individual freedom, the protection of the community from harm, and the facilitation of effective treatment for people with serious mental illness. The Commission hopes that the submissions it receives in response to this Discussion Paper will provide it with feedback on whether this balance has been achieved.

The next part of the Discussion Paper considers the *Hospitals Act* in more detail.[85] In each section, particular issues are identified and discussed, followed by the Commission's suggestions for reform.

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[85] A number of other statutes may also affect people with mental illness in Nova Scotia. They include the *Incompetent Persons Act*, R.S.N.S. 1989, c. 218, the *Inebriates' Guardianship Act*, R.S.N.S. 1989, c. 227, and the *Adult Protection Act*, R.S.N.S. 1989, c. 2. These statutes did not, however, form part of the Reference provided to the Commission and apart from incidental mention, are beyond the scope of this Discussion Paper.

III ISSUES FOR DISCUSSION

A. ADMISSION TO MENTAL HEALTH FACILITIES

Voluntary admissions

Under the *Hospitals Act* a person may be admitted to a facility either voluntarily or involuntarily. A voluntary patient is someone who remains in a facility with his or her consent and upon a physician's recommendation that the person requires the in-patient services provided by the facility.[86] The *Act* refers to such a person as an "informal patient." Most admissions to psychiatric facilities are of the voluntary type.[87] Nonetheless, Canadian mental health legislation, similar to the approach in other countries, focuses almost exclusively on involuntary admission.[88] Consistent with this approach, the *Hospitals Act* contains few references to voluntary admission. The Commission understands that for the most part, concerns about the *Hospitals Act* seem to involve involuntary admission. As a result, this Paper will focus on issues relating to involuntary admission.

Some concerns have been raised and considered by the Commission about voluntary admission. One might ask whether it should be appropriate to allow a minor to become a voluntary patient with the approval of a parent or guardian. The Commission is of the view that the admission of minors to facilities as voluntary patients should more properly be considered as part of a future project, undertaken to examine minors' consent to health care in general. In addition, there is the question of whether to allow the admission, as a voluntary patient, of a person who does not have the capacity to provide or refuse consent to admission. Although not resisting admission, some people may also not expressly consent to admission, but rather may simply acquiesce. The Commission takes the position that admission to facilities should be encouraged for those people who appear willing to seek care and treatment for mental illness. Issues which may affect all patients, such as the capacity to accept or refuse treatment, and the review of decisions involving the nature of one's stay at a facility, will be considered below, in the context of involuntary patients.

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[86] Note 51, above, s. 34(4).

[87] H.A. Kaiser, "Mental Disability Law" in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy* (Markham, Ont.: Butterworths, 1999) 217 at 241.

[88] Robertson, note 2, above, at 242.

Involuntary admissions

1. Involuntary examination and assessment

Should the elements and duration of admission as a person under observation be changed?

Mental health legislation in most Canadian jurisdictions, including Nova Scotia, provides for a person's short-term involuntary admission to a psychiatric facility for the purpose of an examination and psychiatric assessment. The Nova Scotia *Hospitals Act* generally requires certificates from two physicians who have examined the person mentioned in the certificates.[89] In Nova Scotia, when admitted to a facility on a short-term, involuntary basis, an individual is referred to as a "person for observation."[90] Section 42 of the *Act* requires every person admitted for observation to be:

- examined by a physician and psychiatrist within 24 hours and three days, respectively;
- declared by a psychiatrist to be disordered and dangerous or not prior to the eighth day after admission; and
- released prior to the eighth day unless determined to be an involuntary patient, transferred or continuing in the facility as a voluntary patient.

The statutory criteria which must be satisfied before a physician can issue a certificate are usually identical, or substantially similar, to the criteria used for admission as an involuntary patient. In some provinces, however, less rigorous criteria may be applied to admission for examination and assessment than for involuntary admission. For example, the legislation in Nova Scotia provides that at the stage of admission as a person under observation, the standard is one of "reasonable and probable grounds" that the person is suffering from a psychiatric disorder and that the person is a danger to the safety of self or others.[91] At the stage of involuntary admission, greater certainty is required. The psychiatrist must state that the person actually suffers from a psychiatric disorder and that the person is a danger to the safety of self or others.[92]

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[89] Where "compelling circumstances" exist, and a second physician is not available, it is possible to have someone admitted on the basis of one certificate: note 51, above, s. 36(a).

[90] Note 51, above, s. 34(2).

[91] Note 51, above, s. 36(2).

[92] Note 51, above, s. 42(2).

Subsection 34(2) of the *Hospitals Act* permits a person to be kept at a facility for a period of observation of up to seven days. Other provinces have specified periods that can range from 24 hours (Alberta) to one month (British Columbia), with most Canadian jurisdictions prescribing a maximum of 24 to 72 hours confinement.[93]

Some people believe that the period for observation in Nova Scotia should be shorter, with new admissions being examined by a psychiatrist and an assessment being completed within 24 hours. They suggest that more rapid decisions are in order, given that involuntary admission means significant infringements on a person's liberty. Others believe that a decision about a person's status could be made over the course of as many as 72 hours, suggesting that a three-day time frame would allow for a better assessment, taking into account not only psychiatrists' observations, but also the perspectives of other members of the health care professional team. Too little time for completing an assessment could otherwise lead to a cautious approach by psychiatrists, with more decisions being made to commit.

The Commission is of the view that the test to admit persons under observation need not be as stringent as the test for involuntary admission as a patient. In the event of someone who shows signs of having a mental illness and being a danger to self or to others, more of an emphasis should be placed on getting that person to the safety of a facility, where an assessment could be completed. With the passage of time after the original admission, more information would become available about the nature of a person's mental health. Given the availability of additional details, as well as the fact that admission as an involuntary patient would involve significant and perhaps lengthy infringement on personal freedom, the Commission takes the position that the standard for involuntary admission should be higher. To accomplish these aims, the Commission suggests that the current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.

The Commission is conscious of the need to have assessments completed quickly, to lessen infringements on personal freedom. The Commission is also aware, though, of the need for assessments to be based on sufficient information. If psychiatrists do not have adequate time during which to interview and observe a patient, then they may be inclined to err on the side of caution, namely through involuntary admission. To best balance the needs for a speedy and thorough assessment, the Commission suggests that an assessment should be completed as quickly as possible, in compliance with professional standards. The standard time period for completion of an assessment should be 24 hours, with a possibility for an additional 48 hours in exceptional cases.

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[93] Alberta, *Mental Health Act*, S.A. 1988, c. M-13.1, s. 4; British Columbia, *Mental Health Act*, R.S.B.C. 1996, c. 288, ss. 22-23.

The Commission suggests:

- The current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.
- An assessment should be completed as quickly as possible, in compliance with professional standards.
- The standard time period for completion of an assessment should be 24 hours, with a possibility for an additional 48 hours in exceptional cases.

2. Pursuant to medical certificates

Who should have authority to admit persons involuntarily to mental health facilities?

a) Physicians

Under Canadian mental health law, the use of medical certificates is the most common method to secure a person's assessment.[94] In Nova Scotia, section 36 of the *Hospitals Act* provides that two physicians, each of whom must have examined a person, may complete medical certificates in order to have the person admitted involuntarily to a facility.

Medical certificates must state that the physician has reasonable and probable grounds to believe the person is suffering from a psychiatric disorder and should be admitted to a facility because he or she needs in-patient services and requires care that cannot be adequately provided outside the facility, because he or she is a danger to his or her own safety or the safety of others.[95] If the person is to continue as an involuntary patient, prior to the eighth day after admission a psychiatrist must complete a declaration of formal admission stating that the person suffers from a psychiatric disorder and that the person is a danger to the safety of self or others.

In Alberta, New Brunswick, the Northwest Territories, Nunavut, Prince Edward Island, and Quebec, one physician, upon examining the person, is sufficient authority for a person's

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[94] Kaiser, note 87, above, at 242.

[95] Note 51, above. s. 36(2).

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[94] Kaiser, note 87, above, at 242.

[95] Note 51, above. s. 36(2).

involuntary detention and admission.[96] In Yukon, one physician is sufficient authority to detain a person in order to carry out an involuntary assessment, and if a physician is not available, a nurse may complete the assessment.[97] Only a physician, though, may admit a person to a facility in Yukon.[98] Under Manitoba law, only one certificate is required for a person's detention and involuntary medical examination. A psychiatrist, however, is required to confirm the initial physician's certificate in order to involuntarily admit the person beyond the initial detention period.[99] Although similar provisions are found in the Ontario *Mental Health Act*, it does not require the second or confirming physician to be a psychiatrist.[100] In British Columbia and Newfoundland, the decision to admit involuntarily is made by two physicians.[101]

Some people would prefer to see a role in the Nova Scotia system for designated health care professionals other than physicians to be involved in the commitment process. It has been pointed out that in rural communities it may not always be possible for two physicians to be available at the same time. Expanding the range of health care professionals who are entitled to complete medical certificates, it has been suggested, would increase the probability of two certificates being provided quickly.

b) Tribunal

New Brunswick is the only province or territory to have a tribunal system for the involuntary admission of persons under mental health legislation. A tribunal is a body or person exercising a statutory decision-making power outside the regular court system.[102] In New Brunswick, a psychiatrist must apply to a tribunal for an order to admit a person as an involuntary patient.[103] The tribunal has three members, a psychiatrist (or another physician if a psychiatrist is not available), a lawyer and a person who is neither a psychiatrist nor a lawyer. A hearing must

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[96] Alberta, note 93, above, s. 4; New Brunswick, *Mental Health Act*, R.S.N.B. 1973, c. M-10, s. 7.1; Northwest Territories, R.S.N.W.T. 1988, c. M-10, s. 8 (Nunavut has adopted the Northwest Territories statute in its entirety); Prince Edward Island, *Mental Health Act*, S.P.E.I. 1994, c. 39, s. 6; Quebec, arts. 27-29 C.C.Q. [*Civil Code of Quebec*].

[97] *Mental Health Act*, S.Y. 1989-90, c. 28, s. 11.

[98] Note 97, above, s. 13.

[99] *Mental Health Act*, S.M. 1998, c. 36, C.C.S.M. c. M110, ss. 8-9, 17.

[100] *Mental Health Act*, R.S.O. 1990, c. M-7, ss. 15, 20.

[101] B.C. statute, note 93, above, s. 22; Newfoundland, *Mental Health Act*, R.S.N. 1990, c. M-9, s. 5.

[102] D.A. Dukelow & B. Nuse, *The Dictionary of Canadian Law* (Scarborough: Carswell, 1991) at 1103.

[103] N.B. statute, note 96, above, s. 8.

be held within 72 hours. An oral decision is given at the hearing, and a written decision must be provided within 72 hours.[104]

A suggested advantage of a tribunal in the admission process is that it allows for the separation of commitment and treatment roles for physicians, and in particular, psychiatrists. Some have suggested there is a conflict in permitting psychiatrists to be involved in having people admitted to a facility and treating them once they are there. Others have mentioned, though, that potential problems could be involved with adoption of a tribunal system. By itself, it would not guarantee there are enough psychiatrists in rural areas to ensure separation of commitment and treatment roles. Issues concerning legal representation would have to be resolved. The system might also not be able to respond quickly enough in rural areas.

For greater speed and flexibility, rather than using a tribunal which involves three decision-makers, some people prefer the use of a one-person decision-maker, a "judicial arbiter." The judicial arbiter, who would be either a Provincial Court judge or a justice of the peace, would hear medical evidence and decide about a person's admissibility to a facility. In relation to this approach, others have pointed out that decisions about a person's mental health status often have to made quickly in the course of a crisis. There may not always be time for physicians to contact arbiters, in order to familiarize them with the specifics of a situation and any background medical details. Budgets may also not allow for the education of justices of the peace in medical information and issues. In any event, regardless of how well trained, justices of the peace would still have to rely on any medical information that was provided, which would continue the important role in commitment decisions for psychiatrists or other physicians.

c) Courts

Section 37 of the *Hospitals Act* provides for detention and examination by a judicial order. Any person may give information to the Provincial Court of his or her belief, on reasonable and probable grounds, of another person having a psychiatric disorder and being dangerous. Following the receipt of such information, the judge may direct an examination or order the apprehension of the person identified, for the purpose of determining if the person fits the criteria for involuntary admission.

The Law Reform Commission of Saskatchewan recommended against committal decisions being routinely made by the courts. It cited a number of factors, including the judiciary's lack

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[104] The tribunal also makes decisions about compulsory treatment, a topic which is discussed below, at Part III.B.

of training in psychology and psychiatry, the need for deference to medical expertise, and the inevitable delay involved in court proceedings.[105]

Having taken into account the need for speed and flexibility, as well as maintenance of uniformity in standards of service, this Commission is of the view that the current admission process, which largely relies on medical certificates provided by physicians, should be continued. The Commission is concerned that to involve a tribunal at the stage of admitting people for observation could make the process unnecessarily long, complex, and adversarial. Arranging for a tribunal to meet within a sufficiently short time could prove difficult in some rural areas. The Commission is not in favour of adopting a judicial arbiter system. Even if education in medical issues was provided to justices of the peace, a psychiatrist's opinion would still largely determine the matter of admission. Accessibility to a judicial arbiter could be difficult in rural areas. Given their significant individual workloads, physicians may not have time to attempt to contact a judicial arbiter and convey the facts of the situation at hand. Although courts are experienced in protecting and balancing rights, the Commission is not of the view that courts should constitute the primary means of admitting people to facilities. The congested nature of the court system is not consistent with the need in many cases for a quick determination of a person's admissibility. Moreover, courts would still have to rely on evidence provided by psychiatrists or physicians.

From the Commission's perspective, the most efficient and thorough process for making a decision about involuntary admission for the purpose of observation, a decision dependent on medical knowledge and experience, is to continue to entrust it to those people qualified to practice medicine. The Commission suggests that the *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians, or one certificate in compelling circumstances.

The Commission understands that admission to a facility by means of a judicial order occurs infrequently. Nonetheless, the Commission considers this admission route to be a useful one, albeit secondary, which should be retained. It allows for greater flexibility in the admission process. In some situations, physicians may not be available to complete medical certificates. It also allows someone concerned about another person's mental condition to apply for examination of that other person, in situations where the other person would not willingly undergo a psychiatric examination. This route of admission is a balanced one, as court proceedings allow for the person who would be the subject of a warrant for examination to express his or her views. The Commission suggests that the possibility of detention and

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[105] Law Reform Commission of Saskatchewan, *Proposals for a Compulsory Mental Health Care Act* (Saskatoon: The Commission, 1985) at 19. Nevertheless, that Commission was of the opinion there was still a role for courts. The Saskatchewan Commission suggested that court approval should be required to extend a committal period. In that Commission's opinion, such an approach would minimize court involvement, but would still provide adequate protection for the rights of involuntary patients [p. 20].

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3. Criteria

a) Definition of "mental disorder"

How should mental disorder be defined?

One of the criteria for involuntary admission under Canadian mental health legislation is a diagnosis of mental disorder. An equivalent term is defined in each province and territory except Quebec. Nova Scotia's *Hospitals Act* uses the term "psychiatric disorder," which it defines at section 2(q) as "any disease or disability of the mind [including] alcoholism and drug addiction." Newfoundland and Ontario share a definition of "mental disorder" which is similar to that of Nova Scotia: "any disease or disability of the mind."[106] The Alberta, New Brunswick, the Northwest Territories, Nunavut, Prince Edward Island, Saskatchewan, and Yukon have adopted (some with minor changes) the Uniform Law Conference of Canada (ULCC)[107] definition of "mental disorder" which describes more specifically the level of mental impairment and its effects. The ULCC's *Uniform Mental Health Act* defines "mental disorder" as "a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life."[108]

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[106] Newfoundland statute, note 101, above, s. 2(g); Ontario statute, note 100, above, s. 1.

[107] The Uniform Law Conference of Canada (ULCC) is an independent organization which promotes the uniformity of legislation in Canada concerning subjects for which uniformity may be found possible and advantageous.

[108] Uniform Law Conference of Canada, *Proceedings of the Sixty-ninth Annual Meeting*, Appendix F (Victoria, B.C., 1987) at 262.

For some people, the term "mental disorder" is preferable to "psychiatric disorder," since it is broader in scope and less technical. In terms of the definition's content, some have suggested that as the definition would potentially be involved in taking away a person's rights, a narrow definition is required. Some people do not consider it appropriate for conditions such as Alzheimer Disease[109] to be included within the definition, while others are concerned about the inclusion of alcoholism and drug addiction in the current definition of "psychiatric disorder" in the Nova Scotia statute. The counter position is that a more detailed definition can provide greater guidance to health care professionals, and that the Nova Scotia definition is currently too vague.

The Commission is of the view that the more general, less technical term "mental disorder" should be used rather than "psychiatric disorder." The Commission takes the position that the ULCC definition of "mental disorder" is appropriate, being specific enough to provide guidance, but also general enough to allow flexibility in application. The Commission acknowledges there are differing viewpoints on the merits of specifying particular conditions as part of a definition. For instance, the Commission believes that alcohol or drug addiction should not be included, even though it is treated as a psychiatric illness in the *Diagnostic and Statistical Manual*,[110] used by mental health care professionals. The Commission seeks comments on what, if any, conditions should be specifically mentioned in the definition.

The Commission suggests:

- The term "mental disorder" should be used rather than "psychiatric disorder."
- "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.

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[110] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (Washington, D.C.: The Association, 1994).

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b) Dangerousness

Should a person's involuntary admission continue to be based on the concept of dangerousness?

In Canadian mental health law, the second criterion for civil commitment tends to be based on the concept of "dangerousness," which implies that an act of violence or harm will otherwise occur.[111] One way in which the concept of dangerousness is incorporated into mental health legislation is by means of the word "safety." Subsection 36(2) of the *Hospitals Act* establishes a typical "safety test" as the minimal ground for a person's involuntary admission. In part, it insists that a person "requires care that cannot be adequately provided outside the facility because he is a danger to his own safety or the safety of others." A similar approach has been adopted in Prince Edward Island and Newfoundland.[112]

The Prince Edward Island Court of Appeal has stated that the word "safety" goes beyond mere protection from infliction of physical injury and "includes such things as the alleviation of distressing physical, mental or psychiatric symptoms as well as the provision of creature comfort in appropriately congenial physical surroundings."[113]

Rather than using "safety," the British Columbia *Mental Health Act* refers to "protection." Involuntary admission is permitted if the person "requires care, supervision and control in a Provincial mental health facility for the person's own protection or for the protection of others."[114]

In Alberta's legislation, the concept of dangerousness takes the form of a requirement that the person suffering from a mental disorder is "in a condition presenting or likely to present a danger to himself or others."[115] "Danger" in the Alberta statute has been interpreted to mean a serious risk of physical harm, rather than mental or emotional harm.[116]

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[111] J. Arboleda-Flórez & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994) at 1-50.

[112] Newfoundland statute, note 101, above, s. 5; P.E.I. statute, note 96, above, s. 6. Under the Newfoundland statute, the interest of "safety to property" is also a criterion for civil commitment.

[113] *Reference re Mental Health Act* (1984), 5 D.L.R. (4th) 577 at 589.

[114] B.C. statute, note 93, above, s. 22.

[115] Alberta statute, note 93, above, s. 6.

[116] *M.* v. *Alberta* (1985), 63 A.R. 14 at 29 (Q.B.).

Ontario's *Mental Health Act* provides that after examination, a person must be admitted as an involuntary patient if suffering from a mental disorder of a nature or quality that likely will result in:

(1) serious bodily harm to the person,
(2) serious bodily harm to another person, or
(3) imminent and serious physical impairment of the person, unless the person remains in the custody of a psychiatric facility.[117]

In addition to danger, there is the potential to consider a person's welfare. This will be referred to as the "welfare standard." Welfare in this context tries to take into account a person's best interest, to prevent a person from suffering impairment or deterioration. The term "imminent and serious physical impairment" is not intended to relate to persons who have no interest in self-care, but only to situations where a person's life or physical integrity is at stake as a result of his or her mental illness.[118] For example, the court noted in *Foran* v. *O'Doherty* that a history of failing to take medication and being led into undesirable activities, substance abuse, a failure to manage one's money or a slovenly lifestyle will not authorize a person's detention where there is no evidence that the person is likely to suffer serious physical impairment as a result of that behaviour.[119] By contrast, in *B(L) v. O'Doherty*,[120] in choosing to uphold the continuation of an involuntary patient's stay at a facility, the court accepted the probability that upon discharge, the patient would revert to poor eating habits, which would likely result in a stroke. With respect to the meaning of "imminent," Ontario case law appears to suggest that the patient's serious physical impairment would need to occur "in a matter of weeks."[121]

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[117] Ontario statute, note 100, above, s. 20. The reason for adding a third category to the "dangerousness" standard was to broaden the legislation's scope to include those persons whose behaviour, brought on by mental disorder, caused an imminent threat to their life or physical integrity. [Telephone conversation with Ms. Diane Schell, Legal Counsel for the Ontario Ministry of Health, 28 September 1999]. Recent changes to the Ontario statute, to come into effect on December 1, 2000, include deleting the qualifier "imminent" before "physical impairment." See *Brian's Law (Mental Health Legislative Reform, 2000)*, S.O. 2000, c. 9 [hereinafter *Brian's Law*] s. 7(4).

[118] D. Schell, S. Malcolmson & P. Klassen, "The Hospitalized Psychiatric Patient: Clinical and Legal Aspects of Care" in H. Bloom & M. Bay, eds., *A Practical Guide to Mental Health, Capacity and Consent Law of Ontario* (Toronto: Carswell, 1996) 121 at 138.

[119] (November 7, 1986), docket no. 1981/86 Thunder Bay (Ont. Dist. Ct.), cited in Schell et al., note 118, above, at 138-39.

[120] (April 14, 1986), docket no. 1226/86 Thunder Bay (Ont. Dist. Ct.), referred to in Robertson, note 2, above, at 393.

[121] See *G.(G.) v. Swamy*, (April 4, 1986), docket no. 1179/86 Thunder Bay (Ont. Dist. Ct.), *Kletke v. U.(D.)* O.J. No. 1540 (Dist. Ct.), cited in Robertson, note 2, above, at 392-93.

The factor "imminent and serious physical impairment of the person" is also found in the legislation of the Northwest Territories and Nunavut.[122] Manitoba has a similar provision, except its statute requires a "substantial mental or physical deterioration of the person." According to the Yukon *Mental Health Act*, the requirement is that of "impending serious physical impairment."[123] New Brunswick's mental health legislation requires that "the person's recent behaviour presents a substantial risk of imminent physical or psychological harm to the person or to others."[124]

Saskatchewan's *Mental Health Services Act* adopts a very different approach to civil commitment criteria. In addition to the requirement of dangerousness ("likely to cause harm to himself or to others or to suffer substantial mental or physical deterioration"), there must be probable cause to believe that the person is unable, because of mental disorder, to "fully understand and make an informed decision regarding his need for treatment or care and supervision."[125]

Differing perspectives exist on the limits of harm. Some believe it should be limited to serious bodily harm to others or self. Another view is that the use of the term "bodily" is too restrictive, as it would confine the definition to the risk of physical injury, and that psychological harm is also important to take into account. In a Supreme Court of Canada criminal law decision, it was suggested that if psychological harm substantially interferes with a person's health or well-being, it can come within the scope of the phrase "serious bodily harm," and may often be more pervasive and permanent in its effect than any physical harm.[126]

Some people prefer the dangerousness standard, suggesting it is less intrusive than the welfare standard. These people are of the view that the merits of preventing violent acts or physical injuries are clear. They suggest that applying the welfare standard may involve a value judgment about a person's lifestyle. Others point out that even if the welfare standard focuses on deterioration in a person's functioning, to allow impairment to continue unchecked could ultimately lead to harm as severe as that inflicted through an immediate dangerous act. These people point to the example of individuals whose conditions do not make them a present danger to self or others, but who take insufficient care of themselves, a trend which worsens over time, eventually endangering a person's health or life.

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[122] N.W.T. statute, note 96, above, s. 8 (adopted by Nunavut).

[123] Note 97, above, s. 5.

[124] N.B. statute, note 96, above, s. 8(4).

[125] S.S. 1984-85-86, c. M-13.1, s. 24.

[126] *R.* v. *McCraw*, [1991] 3 S.C.R. 72 at 81.

Some people are of the view that civil commitment should not be based on concerns about the safety of either property or finances. In other words, the danger of a person wasting his or her fortune should not be grounds for commitment.

It has also been suggested that a link between the standard of risk and the standard for illness is important. If such a link did not exist, there might be mental illness in an individual but no danger, or an individual might be dangerous, but not have a mental illness.

In terms of the nature of harm that civil commitment is designed to prevent, the majority of the Commission is of the view that bodily harm alone would be too narrow a standard. Some conditions, such as schizophrenia,[127] if left unchecked, though they do not involve actual physical harm to a person, can progressively worsen, with little or no possibility of redressing the deterioration in a person's mental functioning. The majority of the Commission therefore suggests that the Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder not only when bodily harm is likely, but also when there is a likelihood of psychological harm to self.

The majority of the Commission also considers it important for an amended statute to take into account the possibility that harm could occur, not only through an immediate, single act, but also over a longer period and as part of a series of acts. As a result, the majority of the Commission suggests that the statute should include a provision relating to a person's "imminent and serious impairment" as part of the criteria for involuntary admission.

The Commission is of the view that the protection of property and finances from waste should not be part of the standard for commitment. The Commission notes that the state's power to involuntarily hospitalize involves a significant infringement on personal freedom. It would be extending such infringement too far to allow for the hospitalization of someone simply because he or she is dealing with property in an atypical or reckless fashion. The Commission also points out that for those people truly incapable of taking care of their property or finances, guardianship orders are available.[128] As a result, the Commission suggests that neither harm to property nor finances should be available as a ground for a person's involuntary admission to a facility.

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[127] Schizophrenia is a brain disorder, the symptoms of which include disorganized thinking, delusions, hallucinations, and changes in emotions and behaviour: Schizophrenia Society of Canada, "What Exactly is Schizophrenia?" online: Schizophrenia Society of Canada Web site <http://www.schizophrenia.ca/info.html> (date accessed: 26 May 2000).

[128] A guardian is an individual with the right and duty of protecting the person, property, or rights of someone who is not mentally capable or is otherwise unable to manage his or her own affairs: R. Bird, *Osborn's Concise Law Dictionary*, 7th ed. (London: Sweet & Maxwell, 1983) at 160.

To help diminish the potential misuse of civil commitment, the Commission takes the position that the *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and a danger to self or others. This is necessary to avoid the civil commitment of either people who have mental illness, but who do not pose a danger, or of dangerous people without mental illness.

The majority of the Commission suggests:

- The Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder not only when bodily harm is likely to self or others, but also when there is a likelihood of causing psychological harm to self.

- The statute should include a provision relating to a person's "imminent and serious impairment" as part of the criteria for involuntary admission.

The Commission suggests:

- Neither harm to property nor finances should be available as a ground for a person's involuntary admission to a facility.

- The *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and a danger to self or others.

4. Peace officers

Should the current procedure for the involvement of peace officers be revised?

The *Hospitals Act* provides for the involvement of peace officers in the civil commitment process in a number of ways. Following receipt of duly completed medical certificates or a warrant, a peace officer is required to apprehend the identified person so that an examination can be completed. Subsection 38(1) permits a peace officer who reasonably believes that a person is mentally disordered and that the person is dangerous, or is committing or about to commit an indictable offence, to take the person to an appropriate place for examination. It states:

> *Where a peace officer has reasonable and probable grounds to believe that a person suffers from a psychiatric disorder and*
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> *(a) is a danger to his own safety or the safety of others; or*

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(b) is committing or about to commit an indictable offence,

the peace officer may take the person to an appropriate place where he [or she] may be detained for medical examination.

Subsection 39(3) provides in part that when a person has been brought by a peace officer to a facility for examination, and the person is not admitted, he or she shall be returned to the place where apprehended. That subsection does not indicate, though, whether peace officers are expected to return the person. Section 46 of the *Hospitals Act* authorizes peace officers to return to a psychiatric facility those persons who have been involuntarily admitted, yet who are absent from the facility without authorization.

Similar to section 38 of the *Hospitals Act*, all other provincial and territorial mental health statutes contain provisions which address a person's apprehension by peace officers for the purpose of a psychiatric assessment. It is also common, though not required by Nova Scotia law, that a peace officer is specifically required to retain care and custody of an apprehended person until completion of the psychiatric assessment, at which time the person is either admitted to the facility or released.[127] In Manitoba, for example, the *Mental Health Act* formerly required peace officers who had taken a person into custody for the purpose of an involuntary examination to remain at the place of examination and to retain custody of the person until the examination was completed or the person was admitted as a patient to a facility. Manitoba police, in submissions to a legislative committee reviewing the Manitoba legislation, expressed concern about having to wait long periods in hospital emergency departments while psychiatric assessments were being completed. As a result of these lengthy waiting periods, usually one or two police officers and their vehicle were removed from other service.[128] Manitoba legislation now provides that a peace officer's duty to retain custody of a person apprehended for the purpose of an involuntary examination or assessment does not apply "if the physician conducting the examination or assessment advises the peace officer that continuing custody is not required."[129] The Manitoba statute also states that if a peace officer apprehends a person and brings that person to a facility for the purpose of an involuntary examination or assessment, but the person is not admitted, then the peace officer shall, if practicable, return the person to the place where he or she was apprehended, or to another appropriate place.[130]

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[127] The Commission understands that peace officers in Nova Scotia, though not required to do so by statute, tend to remain at a facility while an assessment is being completed.

[128] Manitoba, Department of Health, Mental Health Review Committee, *Report of the Mental Health Act Review Committee* (N.p.: [Minister of Health], 1997) at 41-44.

[129] Note 99, above, s. 15.

[130] Note 99, above, s. 15.

The Commission is of the view that clause 38(1)(a) of the Nova Scotia statute, which refers to a person who is dangerous to his or her own safety or the safety of others, is wide enough to take into account the situations covered by clause (b), which refers to indictable offences. Indictable offences, which are generally more serious criminal offences, can involve harm to either persons or property. The Commission takes the position that there should be no confusion of the criminal law and the law of civil committal. In the Commission's perspective, either a person should be arrested and dealt with by the courts for an alleged criminal offence, or should be brought to a facility for a psychiatric assessment if he or she meets the standard of appearing to be mentally disordered and dangerous. As a result, the Commission suggests that clause 38(1)(b), which provides for the apprehension of a disordered person "committing or about to commit an indictable offence," is not necessary and should be removed.

The Commission is also of the view that once a peace officer has apprehended and brought a person to a facility for an examination, it should not be necessary for the peace officer to remain, unless the safety of the apprehended person or other people might be endangered. It would make better sense to free the peace officer to tend to his or her other duties. This could be especially important in rural areas of the province, where police detachments can be small and patrol areas large. Depending on the workload at a facility, it might be a number of hours before an assessment could be completed. The Commission therefore suggests that as in Manitoba, peace officers should be permitted to leave a facility during the time that the person apprehended and brought in by the peace officers is being assessed. To avoid misunderstandings, consent for peace officers to depart a facility should be in writing.

If the result of an assessment is that a person meets the standard for involuntary admission, then peace officers will not be required to return to a facility. If a person does not meet the involuntary admission standard, then another issue which arises is whether peace officers should be informed. Rather than arresting a person and charging that person with a criminal offence, in compliance with section 38 peace officers may have brought the person directly to a facility for an assessment. Although the assessment may indicate that the person does not meet the criteria for involuntary admission, peace officers may still wish to charge the person with a breach of the criminal law. Peace officers might be reluctant to release a person into the custody of a facility if there was a chance that the person might walk free after the assessment. This reluctance would be understandable, given the possibility of a criminal suspect reoffending, particularly in the context of domestic violence. Some people have therefore suggested that health care providers should have a duty to inform peace officers when an assessment is completed and a person brought to a facility by peace officers is not admitted. On the other hand, implementing that suggestion would involve a significant infringement of personal privacy. The Commission understands that Nova Scotia hospitals do not on their own initiative inform peace officers of medical details which could signal that a crime has taken place. A common example is that of the injured motorist whose blood sample, taken for other purposes, reveals an alcohol level which could point to an impaired driving offence having been committed. To impose a duty on health care providers to inform peace officers when an

assessment has been completed and a person not admitted to a facility could be seen as unjustifiably treating people with mental disorders differently from others who enter a facility for an examination or treatment. This treatment may also constitute an infringement of section 15 of the *Charter*, which provides for equality under the law and protects against discrimination.

The majority of the Commission acknowledges the concern about infringement of personal privacy and discrimination, but on balance, is of the view that in this context, the protection of public safety should take precedence over privacy rights. The majority of the Commission takes the position that facility staff should have a duty to inform peace officers when the psychiatric assessment of a person brought to a facility by peace officers is completed and the person is not admitted to the facility. This would not require facility staff to incriminate people, by informing peace officers of suspicions that a crime has taken place. Rather, peace officers would already have been involved in bringing the person to the facility, given an element of danger. The responsibility to decide whether a danger was sufficiently serious to require intervention of the criminal law would remain with peace officers. The majority of the Commission is of the view that without creating a duty to notify, the advantage of its suggestion about allowing police to depart a facility during an assessment would be largely undermined. Concerns about a person reoffending might cause police to remain at a facility in any event.

The record of a patient's interactions with peace officers might have a bearing on the duration of the patient's stay in a facility. The Commission is of the view that a patient should have access to all relevant information concerning his or her admission to a facility. As a result, the Commission suggests that the *Hospitals Act* should require copies of relevant police reports to be included in a patient's psychiatric file.

The Commission suggests:

- Clause 38(1)(b) of the *Hospitals Act*, which provides for the apprehension of a disordered person "committing or about to commit an indictable offence," is not necessary and should be removed.

- Peace officers should be permitted to leave a facility during the time that a person apprehended and brought in by the officers is being assessed. To avoid any misunderstandings, consent for peace officers to depart a facility should be in writing.

The majority of the Commission suggests:

- Facility staff should be required to inform peace officers when a psychiatric assessment of a person brought to a facility by peace officers is completed and the person is not admitted as an involuntary patient.

The Commission suggests:

- Copies of relevant police reports should be included in a patient's psychiatric file.

5. Detention periods

a) Initial period of detention

Is the current duration of an initial admission certificate appropriate?

In provincial and territorial mental health law, the initial period of involuntary detention pursuant to an admission certificate (sometimes referred to as a "declaration of formal admission") ranges between two weeks and one month.[131] In Nova Scotia, subsection 44(2) of the *Hospitals Act* states that no person is to be detained in a facility as an involuntary patient for an initial period longer than one month.

For the length of an initial detention period, the Commission considers it important to attempt a balance. On the one hand, adequate time is needed to enable health care professionals to observe, interview and, if necessary, treat a patient. Too short an initial period might mean that health professionals are not able to give their fullest attention to a patient. Moreover, as the opinions of health care professionals might be challenged before a review board or court,

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[131] See Kingma, note 18, above, at 222-224.

they require adequate time for a thorough evaluation of a patient. On the other hand, it is important not to overlook that involuntary hospitalization involves a significant infringement of a patient's personal freedom. The Commission is of the view that this infringement should be as short as necessary. The Commission takes the position that an initial detention period of one month best balances the need to give health care professionals adequate time with the need to minimize intrusions on personal freedom. The *Hospitals Act* currently provides for an initial detention period of one month. The Commission therefore suggests that this period should be retained.

The Commission suggests:

- The current initial detention period of one month for an involuntary patient should be retained.

b) Renewal certificates

Should the duration for renewal certificates be maintained?

A person's initial involuntary hospitalization period can be extended if the original admission certificate is renewed. Similar provisions providing for the extension beyond the initial period of detention through the use of "renewal certificates" are found in most other provinces and territories.

In Nova Scotia, renewal, governed by section 44 of the *Act*, takes the form of examination by a psychiatrist, who may then certify that the patient should remain in the facility. Unless no other psychiatrist is available, an examination for the purpose of deciding on renewal must be done by a psychiatrist other than the one who signed the declaration of formal admission or a previous renewal declaration. The criteria for issuing a renewal certificate are the same as for the initial admission certificate or declaration of formal admission. A declaration of formal admission can be renewed for a three month period and a second three month period. Any additional renewal period is for six months.

In most Canadian jurisdictions, the renewal periods eventually increase to either six months or one year. Ontario and Manitoba are atypical in limiting the maximum renewal period to three months, while both Saskatchewan and Yukon ordinarily limit each renewal period to 21 days.[132]

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[132] Ontario statute, note 100, above, s. 20; Manitoba statute, note 99, above, s. 21; Saskatchewan statute, note 125, above, s. 24; Yukon statute, note 97, above, s. 16.

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Some people believe that in all cases, given the significant reduction of personal freedom involved with involuntary hospitalization, the duration of a renewal certificate should be as short as possible. Others point out that in long-term cases, having a monthly review would accomplish little. It has also been mentioned, though, that to not have the possibility of reviewing a patient's status on a more frequent basis could lead to complacency among health care staff at a facility and therefore, unnecessarily long detentions.

Another view, keeping in mind the protection of patients, is that rather than a psychiatrist renewing a detention certificate on his or her own, renewal decisions should be made by a review board. At the time of each renewal application, the civil commitment criteria would have to be established. Others believe that even if the renewal process remains the responsibility of psychiatrists, then the same psychiatrist should not be involved.

The Commission takes the position that the length of renewal periods should reflect a balance between the need to properly evaluate a patient and the need to limit restrictions on a patient's personal freedom. If renewal periods are too short, then too many resources could be devoted to the review process. For instance, the Commission thinks that as far as possible, psychiatrists should be involved in evaluating and treating patients, rather than being occupied with reviews. It should not be overlooked, though, that if renewal periods are too long, in light of current psychiatric practice and available resources, then some patients may spend more time in hospital than is warranted. The Commission is of the view that an appropriate standard would be that proposed by the ULCC. Under the *Uniform Mental Health Act*,[133] a declaration of formal admission can be renewed for a one month period, followed if needed by a two month period, in turn followed if required by a three month period. Any additional renewal periods would be for three months.

The Commission is not in favour of altering the involvement of psychiatrists in the current renewal process. Insisting in all cases on a psychiatrist who is different from the one who completed an assessment could be difficult to attain in practice. In some rural areas, it may not be possible to find more than one practising psychiatrist. Moreover, the community of psychiatrists is relatively small in Nova Scotia. Psychiatrists involved at the renewal stage might be reluctant to criticize opinions provided at the assessment stage. As the renewal process largely involves medical evaluation and the extent, if any, to which a patient's condition has improved, the Commission does not consider there to be a need to transfer the responsibility for renewal applications to a review board. As a result, the Commission suggests that the responsibility for renewal examinations should remain with psychiatrists. As is currently the case, unless no other psychiatrist is available, an examination for the purpose of a renewal certificate should be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal certificate.

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[133] Note 108, above, s. 14.

Having said this, the Commission acknowledges the need for a review body to have the responsibility to resolve any disputes involving the nature or duration of renewals. These matters should be heard by the review board, given its familiarity with mental health issues.

The Commission suggests:

- A declaration of formal admission should be renewable for a one month period, followed if needed by a two month period, in turn followed by a three month period. Any additional renewal periods would be for three months.
- Unless no other psychiatrist is available, an examination for the purpose of a renewal certificate should continue to be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal certificate.
- The responsibility for renewal examinations should remain with psychiatrists.
- Any disputes involving the nature or duration of renewals should be heard by the review board.

B. TREATMENT

1. Mental capacity to consent to treatment

In order for a person to give a valid consent to treatment, he or she must be mentally capable. Mental capacity is an individual's ability to make reasoned decisions after weighing the risks, benefits, and other factors. A number of issues have arisen under the *Hospitals Act* concerning mental capacity to consent to treatment.

a) Capacity determination

When should a capacity determination occur?

At common law every person is presumed to be capable of making treatment decisions, until the contrary is determined. The fact that patients, whether voluntary or involuntary, are hospitalized in a psychiatric facility in order to obtain care and treatment for a mental disorder does not necessarily render them incapable of making psychiatric treatment decisions.[134] Section 51 of the *Hospitals Act*, however, requires every person admitted to a facility to be examined within three days of admission, in order to have his or her capacity to consent

[134] *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.) [hereinafter *Fleming v. Reid*] at 86.

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determined. Section 55 also provides for periodic capacity examinations of a person in a hospital. Sections 51 and 55 therefore do not seem consistent with the common law.[135]

Some people have suggested that the mere presence of a person in a facility should not be adequate to set into effect a capacity determination. They would prefer a capacity determination to take place only upon reasonable and probable grounds. Others, however, are of the view that a person's admission to a facility as an involuntary patient should be enough to justify a capacity determination.

The Commission takes the position that for the benefit of patients and the guidance of mental health care professionals, an amended statute should make clear the common law presumption that a person is capable of making treatment decisions, until the contrary is determined. The Commission is of the view that requiring every person admitted to a facility to be examined for capacity to consent to treatment is not consistent with the common law. As a result, the Commission suggests that the *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions until the contrary is determined.

The Commission is of the view that a capacity determination should occur when needed, namely when an issue arises as to the person's capacity to consent to treatment. For example, a psychiatrist may develop a concern about a patient's capacity if the patient objects to or refuses treatment. Another example might be where the patient insists on an unusual or unnecessary course of treatment.

The Commission suggests:

- The *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions, until the contrary is determined.
- A capacity determination should take place only when an issue arises about a patient's capacity.

[135] At s. 56, the *Hospitals Act*, note 51, above, contains a provision relating to the presumption of capacity, but its scope is unclear. Section 56 indicates that if a periodic examination is not conducted within the time frames set out in s. 55, then the person to be examined shall be presumed to be competent or capable of consenting to treatment until a psychiatrist determines otherwise. Section 56 does not refer to a presumption of capacity that applies when a person enters a facility.

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b) Factors for determining capacity

Should the current factors for determining a person's capacity be revised?

Subsection 52(2) of the *Hospitals Act* requires a psychiatrist, in determining a person's capacity, to consider whether or not the person being examined :

> *(a) understands the condition for which the treatment is proposed;*
> *(b) understands the nature and purpose of the treatment;*
> *(c) understands the risks involved in undergoing the treatment;*
> *(d) understands the risks involved in not undergoing the treatment; and*
> *(e) whether or not his [or her] ability to consent is affected by his [or her] condition.*

In Ontario, a person is considered "mentally capable" concerning treatment if the person is able to understand the information relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of making a decision or not.[136] Alberta uses the term "mental competence" in this context. A person is deemed mentally competent to make treatment decisions if able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions.[137]

Under Yukon legislation, to be considered "mentally competent" a patient must understand:[138]

> (1) the condition for which treatment is proposed;
> (2) the nature and purpose of the treatment;
> (3) the risks involved in having the treatment; and
> (4) the risks in not having the treatment.

Manitoba and Prince Edward Island, similar to Nova Scotia, add a fifth stipulation, namely, whether the ability to consent is affected by the condition of the patient.[139]

There are no specific provisions for establishing capacity to consent to treatment in the legislation of British Columbia, New Brunswick, Newfoundland, Northwest Territories, Nunavut, Quebec, and Saskatchewan.

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[136] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 4.

[137] Alberta statute, note 93, above, s. 26.

[138] Note 97, above, s. 19.

[139] Manitoba statute, note 99, above, s. 24; P.E.I. statute, note 96, above, s. 23.

Some people are of the view that clause 52(2)(e) of the Nova Scotia statute, which involves whether or not a person's ability to accept or refuse consent is affected by his or her condition, is not necessary. Others suggest this clause is required, as some mental disorders can impair a person's ability to appreciate that he or she has a condition. Without such an understanding, it is suggested, a person would likely not consent to any treatment.

The Commission acknowledges there are some conditions which can impair a person's ability to provide a consent based on an appreciation of all relevant factors. If a mental disorder prevents a person from accepting that he or she has a particular condition, then any consent or refusal of consent by that person could not have followed an appreciation of all relevant factors. The Commission takes the position that subsection 52(2), which sets out factors for a psychiatrist to consider in determining a person's capacity to consent to treatment, should remain unchanged.

The Commission suggests:

- The factors at subsection 52(2) of the *Hospitals Act,* which a psychiatrist must consider in determining a person's capacity to consent to treatment, should remain unchanged.

c) Capacity assessors

Who should assess capacity?

Section 53 requires all capacity determinations in a facility to be done by a psychiatrist. Some people believe that not only could capacity determinations be done by other suitably qualified health care professionals, but also that they may be more appropriate in certain circumstances. For example, geriatricians (physicians who specialize in seniors' health care) may be more qualified to assess an older person's capacity.

Others, though, do not agree with allowing capacity assessments to be done by any health care professionals other than psychiatrists. These people point to the expertise of psychiatrists in mental health issues generally, and more particularly, to the experience of psychiatrists in considering the relationship between capacity and a person's legal rights.

The Commission is of the view that in addition to psychiatrists, other health care professionals may have the relevant combination of education and experience to qualify them to make capacity assessments. Rather than focusing on the designation of the health care professional involved, the Commission thinks that relevant training and expertise are the keys. As a result, the Commission suggests that in addition to psychiatrists, other specially qualified health care

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2. Informed consent

Should the common law elements of informed consent, including the standard of disclosure, be made part of the legislation?

A physician is obliged to obtain a patient's consent prior to the administration of treatment. A valid consent must be: (1) specific to the proposed treatment; (2) given voluntarily; (3) given by a person who is mentally capable; and (4) informed.[140] In relation to the last factor, that consent be informed, the Supreme Court of Canada in *Hopp* v. *Lepp* imposed an obligation on Canadian physicians to disclose "the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation."[141] In a subsequent decision, *Reibl* v. *Hughes*, the Supreme Court affirmed this standard and, among other things, proposed that disclosure should be based on whether a reasonable person in the same position as the patient would not have undergone the treatment if he or she had been properly informed of the risks.[142]

Subsection 54(1) of the *Hospitals Act* requires consent to be obtained before treatment is administered. It does not, however, explicitly state that the consent is to be "informed." Furthermore, the *Act* does not provide any elaboration with respect to the elements of consent or the standard of disclosure.

The mental health law of most other Canadian jurisdictions includes consent provisions, and most of those provisions are similar to the one in place in Nova Scotia. Ontario, however, sets

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[140] H. Savage & C. McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 100-105.

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out specific details about the elements of informed consent, including the required standard of disclosure. Section 11 of the Ontario *Health Care Consent Act, 1996* provides:[143]

> *(2) A consent to treatment is informed if, before giving it,*
> *(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and*
> *(b) the person received responses to his or her requests for additional information about those matters.*
>
> *(3) The matters referred in subsection (2) are:*
> *1. The nature of the treatment.*
> *2. The expected benefits of the treatment.*
> *3. The material risks of the treatment.*
> *4. The material side effects of the treatment.*
> *5. Alternative courses of action.*
> *6. The likely consequences of not having the treatment.*
>
> *(4) Consent to treatment may be express or implied.*

For the protection of patients' rights and for the guidance of psychiatrists, the Commission is of the view that the elements of informed consent should be set out in the *Hospitals Act* as they are identified in the Ontario legislation. The *Act* should indicate that prior to receiving a particular treatment, a patient must provide his or her informed consent. This would mean that the patient was informed about the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment. The Commission is also of the view that the elements of informed consent should be incorporated as part of any standard forms used in compliance with the *Act*. Forms should include a section for a psychiatrist to complete, in order to confirm that informed consent was discussed with a patient.

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[143] Note 136, above.

The Commission suggests:

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- The elements of informed consent should be set out in any standard forms used in compliance with the *Act*.

3. Consent to treatment and compulsory treatment

a) Compulsory treatment

Should compulsory treatment be allowed under certain circumstances?

At common law, everyone has the right to refuse unwanted medical treatment.[144] This common law principle was considered in the context of psychiatric treatment in *Fleming v. Reid*. In that case, the Ontario Court of Appeal stated that a capable person was entitled to control the course of his or her medical treatment. A capable person's right to self-determination was not forfeited when he or she entered a psychiatric facility.[145]

An issue which arises here is whether compulsory treatment can be administered in certain circumstances to patients with mental illness. Subsection 54(1) of the *Hospitals Act* provides that no person admitted to a hospital shall receive treatment unless he or she consents.

In Newfoundland, treatment can be given without consent to a person who is an involuntary patient and who is not capable of consenting to treatment,[146] and in British Columbia, an involuntary patient is deemed to have consented to the treatment authorized by the director of the mental health facility.[147] Under Alberta law, a review panel can order treatment over the objections of an involuntary patient, if the panel determines that the treatment is in the

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[144] *Malette* v. *Schulman* (1990), 72 O.R. (2d) 417 at 424 (C.A.).

[145] *Fleming v. Reid*, note 134, above, at 86.

[146] Newfoundland statute, note 101, above, s. 5.

[147] B.C. statute, note 93, above, s. 31.

The Commission suggests:

- The *Hospitals Act* should require that prior to receiving a particular treatment, a patient must provide his or her informed consent. This would mean that the patient was informed about the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment.

- The elements of informed consent should be set out in any standard forms used in compliance with the *Act*.

3. Consent to treatment and compulsory treatment

a) Compulsory treatment

Should compulsory treatment be allowed under certain circumstances?

At common law, everyone has the right to refuse unwanted medical treatment.[144] This common law principle was considered in the context of psychiatric treatment in *Fleming v. Reid*. In that case, the Ontario Court of Appeal stated that a capable person was entitled to control the course of his or her medical treatment. A capable person's right to self-determination was not forfeited when he or she entered a psychiatric facility.[145]

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patient's best interest.[148] Legislation in Ontario allows a review board to override the consent or refusal to consent of patients and substitute decision-makers, under certain circumstances.[149] Manitoba legislation permits a review board to override the refusal to consent to treatment by a patient's competent proxy or a patient's nearest relative.[150]

Under the *Uniform Mental Health Act*, an involuntary patient has the right not to be given psychiatric treatment or other medical treatment without his or her consent, a consent made on his behalf, or an order of the review board authorizing such treatment. Before authorization, the review board must be satisfied that the mental condition of the patient will either be substantially improved by the treatment or will not improve without the treatment and that the benefit to the patient will outweigh the potential risk of harm.[151]

In considering the merits and detriments of compulsory treatment, some people have expressed the concern that to insist upon a patient's consent as a prerequisite to treatment in all cases could result in patients being kept in a facility, but not receiving any treatment. This would mean that for some patients, facilities become mere detention centers. To avoid that situation, it has been suggested there are instances where compulsory treatment can be justified.

Other people are of the view that compulsory treatment cannot be justified, in light of the common law's requirement for consent and the protection of personal rights and freedoms in the *Charter*. These people suggest that the criminal justice system, not psychiatric facilities, should be used to control those persons who prove themselves dangerous.

The Commission is of the view that generally, treatment should only proceed when a patient has provided his or her consent. Consent can be given by a patient directly, or a patient, while still mentally capable, can communicate in advance his or her wishes concerning health care, in a document known as an advance health care directive, which anticipates the possibility of future mental incapacity. The advance health care directive may appoint a representative, known as a "substitute decision-maker" or "proxy," to make health care decisions, may set out general principles or specific instructions about how a person's health care is to be managed, or may do both. In Nova Scotia, however, the *Medical Consent Act* only provides for the use

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[148] Alberta statute, note 93, above, s. 29. A recent Alberta case held that if a patient with a mental disorder could express neither his or her consent nor objection to the proposed course of treatment, then the patient should not be deemed to have objected to the treatment. As a result, the review panel could not impose the proposed treatment: *B.(M.) v. Alberta (Minister of Health)* (1998), 149 D.L.R. (4th) 363 at 370 (Alta. Q.B.).

[149] In *M.(A.) v. Benes* (1999), 180 D.L.R. (4th) 72 (Ont. C.A.) the Ontario review board's ability to override a substitute decision-maker's choice concerning treatment, where there were no prior expressed wishes, was upheld.

[150] Manitoba statute, note 99, above, s. 30.

[151] ULCC statute, note 108, above, ss. 25-26.

of a proxy-type advance health care directive.[152] However, in those situations for which a person has not appointed a proxy through an advance health care directive and has become mentally incapable, the majority of the Commission is of the view that it should be possible for a review board to approve compulsory treatment.

The majority of the Commission suggests:

- In those situations for which a person has not appointed a proxy through an advance health care directive, it should be possible for a review board to approve compulsory treatment if the person has become mentally incapable. Before authorization, the review board must be satisfied that the mental condition of the patient will either be substantially improved by the treatment or will not improve without the treatment and that the benefit to the patient will outweigh the potential risk of harm.

b) Psychosurgery and other specialized psychiatric treatment

Should the statute allow psychosurgery? Should there be a specific consent provision for other specialized psychiatric treatment?

In addition to its general consent provisions, section 60 of the *Hospitals Act* refers to the consent requirements associated with psychosurgery.[153] Comparable provisions are found in the mental health legislation of other Canadian jurisdictions.

The infrequent use of psychosurgery in Nova Scotia gives rise to the question whether the province's mental health legislation should continue to include a provision related to psychosurgery, and if so, whether this should be expanded to include other specialized psychiatric treatment, such as electroconvulsive therapy (ECT).[154]

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[152] R.S.N.S. 1989, c. 279. For additional discussion of advance health care directives, see Part III.B.6, below.

[153] Psychosurgery is brain surgery for the purpose of treating a mental disorder: J.M. Hawkins & R. Allen, eds., *The Oxford Encyclopedic English Dictionary* (Oxford: Clarendon Press, 1991) at 1167. During the past 18 years, no hearings have been held by the Psychiatric Facilities Review Board to determine whether psychosurgery could be performed: Nova Scotia, Psychiatric Facilities Review Board, *Annual Report: April 1, 1998 - March 31, 1999* ([Halifax: The Board, 1999]) at 5.

[154] Electroconvulsive therapy is the treatment of mental disorder by producing unconsciousness and convulsions through the use of an electric current: F.C. Mish, ed., *Webster's Ninth New Collegiate Dictionary* (Markham, Ont.: Thomas Aller & Son, 1991) at 401-402.

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Some people are of the view that psychosurgery, being unnecessary and unhelpful, should be eliminated, both in practice and in the legislation. Other people have pointed out that regardless of one's opinion concerning the effectiveness of psychosurgery, referring to it in the statute will permit a review board to monitor any new psychosurgery techniques that are developed.

Differing views also apply with respect to mentioning ECT in the legislation. Given concern about the potential lack of effectiveness and the side-effects of ECT, there is some suggestion that it requires close supervision, which can be done by giving a review board monitoring powers in the statute. Another view is that to retain a form of treatment in a special legislative category suggests it is of an extraordinary nature, which could be frightening to some members of the public. Although the misuse of ECT is possible, this is so with all forms of medical treatment.

It has also been pointed out that in addition to psychosurgery and ECT, other types of treatment could be a cause of concern. It has therefore been suggested that rather than specifying particular treatment as being in need of close supervision, review boards should be given the power to supervise, and if necessary, refuse to approve, certain treatment.

The Commission takes the position that the most effective approach for dealing with unusual types of treatment is that in use in New Brunswick. Rather than attempting a list of what is unusual treatment, the New Brunswick statute defines routine clinical medical treatment. It is referred to as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder."[155] Extraordinary types of treatment must be approved by a review board.[156] This approach is more effective, as it frees the Legislature from having to identify and define unusual forms of treatment and places the burden of establishing the need for an atypical procedure on those who seek to employ it. The Commission is also of the view that the New Brunswick provision strikes a balance between protecting people from ineffective forms of treatment and allowing medicine to progress through the development of new treatment. The Commission therefore suggests that the *Hospitals Act* should define routine clinical medical treatment, with extraordinary types of treatment to be approved by a review board.

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[155] N.B. statute, note 96, above, s. 1.

[156] Note 96, above, s. 8.11.

The Commission suggests:

- The *Hospitals Act* should define routine clinical medical treatment, with extraordinary types of treatment to be approved by a review board.
- Routine clinical medical treatment should be defined as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder."

c) Substitute consent and substitute decision-makers

How should a substitute decision-maker make decisions on behalf of another person? What if a dispute arises among substitute decision-makers?

With the exception of British Columbia and Newfoundland, substitute consent provisions are included in the law of all provinces and territories. In Nova Scotia, if a person in hospital is incapable of consenting to treatment, subsection 54(2) of the *Hospitals Act* permits treatment of the person if consent is obtained, from the person's guardian, spouse or next of kin, or the Public Trustee. The *Hospitals Act* does not offer any guidance as to what factors should be considered by substitute decision-makers. Section 2 of the *Medical Consent Act* also allows a person who is 19 years of age and capable of giving consent to medical treatments to authorize another adult to give that consent at a future time when the person giving the authorization is no longer capable.[157]

The *Uniform Mental Health Act* provides that a substitute decision-maker is to base his or her consent or refusal on the wishes, if clearly known, of the patient, expressed when the patient was mentally competent and sixteen or more years of age. Otherwise, consent is to be given or refused in accordance with the best interest of the patient. Best interest is to be determined according to:[158]

i) whether or not the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
ii) whether or not the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment;

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[157] Note 152, above.

[158] Note 108, above, s. 24.

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iii) whether or not the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and

iv) whether or not the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the prior three requirements.

Whether appointed through an advance health care directive or by virtue of legislation, it is possible that more than one substitute decision-maker of the same rank could exist. The legislation in most Canadian jurisdictions, including the *Hospitals Act*, does not mention how to resolve disputes among substitute decision-makers of the same rank.

The ULCC *Uniform Act* does address this issue. It provides that the attending physician of an involuntary patient may apply to the review board for an order authorizing treatment if, among others, two or more persons occupying the same rank in the list of substitute decision-makers claim the authority to give or refuse consent for the patient.[159] This approach is followed in the Northwest Territories, Nunavut, and Yukon.[160] In P.E.I., subsection 23(6) of the *Mental Health Act*[161] seems to indicate that if a patient does not have a guardian, then the attending psychiatrist may choose the most appropriate substitute decision-maker. An application to the review board by any person acting on behalf of an involuntary patient may be made for a review of the choice of substitute decision-maker.[162] For conflicts among substitute decision-makers of the same category in New Brunswick, the legislation allows the person seeking the consent to treatment to file an application with the review board.[163] In Ontario, when two or more persons are part of the same category of substitute decision-makers, if both claim the authority to consent or refuse, if they disagree about the decision, and if there are no other claims of higher authority, then the person who seeks to refuse the treatment shall prevail.[164]

It has been suggested that the *Hospitals Act*, through the inclusion of additional detail, should provide more guidance for substitute-makers and other people, such as psychiatrists, with whom they interact in relation to a patient. An example of more guidance would be a list of factors for a substitute decision-maker to take into account when deciding on a matter for which there were no prior expressed wishes. More guidance could also take the form of direction about how to resolve a dispute between substitute decision-makers of the same rank.

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[159] Note 108, above, s. 26(1)(c).

[160] N.W.T. statute, note 96, above, s. 19.3 (adopted in Nunavut); Yukon statute, note 97, above, s. 23.

[161] P.E.I. statute, note 96, above.

[162] Note 96, above, s. 28(1)(e).

[163] N.B. statute, note 96, above s. 8.6(5).

[164] Ontario statute, note 100, above, s. 2(4).

The Commission acknowledges that being a substitute decision-maker is a significant and perhaps daunting responsibility. Those people who act as substitute decision-makers under the *Hospitals Act* currently receive no guidance from the statute. The Commission is of the view that the *Act* should provide guidance for substitute decision-makers. The first factor to consider would be any prior expressed wishes. If there were none, or if they were unclear, then the best interest of the patient would be taken into account. The Commission suggests that factors equivalent to those in the *Uniform Mental Health Act* should be adopted to help determine a patient's best interest.

In the event of a dispute between substitute decision-makers of the same rank, the Commission does not consider it appropriate for the treating psychiatrist to resolve the impasse or to proceed on his or her own initiative. The psychiatrist might not be perceived as impartial, as he or she would have the same opinion on the need for treatment as one of the disputing substitute decision-makers. Rather, the Commission thinks that an objective third party, namely the review board, should resolve disputes between substitute decision-makers. The Commission suggests that in the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

The Commission suggests:

- A substitute decision-maker should be required to take into account any prior expressed wishes by a person. If there are no prior expressed wishes, or if they are unclear, then a substitute decision-maker should take a person's best interest into account.

- In the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

4. Emergency exception to consent requirement

Should there be a statutory emergency exception provision?

Although the informed consent of a patient or substitute decision-maker is required before the administration of treatment, there are exceptions to this general rule. One such exception is in the event of an emergency. Consent may be dispensed with in certain situations where the patient is not able to provide consent and the patient's life or health is in danger. This is known as the emergency exception or the doctrine of necessity. The emergency exception will not apply, however, where it is merely convenient for a physician to proceed without a

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patient's consent. The emergency exception will also not be available where the patient, prior to the emergency situation, clearly indicated disagreement with a particular procedure.

The emergency exception has been specifically mentioned in a number of provincial and territorial mental health statutes. For example, the Ontario *Health Care Consent Act* states that an "emergency" exists "if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm."[165] A treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment, there is an emergency and the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

In Nova Scotia, the *Hospitals Act* does not provide for the administration of treatment, without consent, in the event of an emergency. At common law, however, if a delay in treatment will threaten the life or health of the patient, the physician may proceed without obtaining consent.[166]

It has been suggested that if a physician was not aware of the common law or was wary of following it, the lack of an emergency exception in the statute could lead to delays in providing treatment. When a patient has no advance health care directive and no next of kin, and a physician does not wish to proceed solely on the basis of the common law, then consent for treatment would have to be obtained from the Public Trustee.[167] Depending on when a consent request is received, it would be several days before the Public Trustee's office collects enough information on which to base a decision.

Some people, though acknowledging the usefulness of inserting an emergency exception into the *Act*, do not agree on how the nature of the exception should be defined. For example, there is the question whether the harm to be avoided should relate only to serious bodily harm or death Others believe the definition should be wider in scope and should include severe suffering. In an emergency situation where a substitute decision-maker has been nominated, but has not been contacted, there is also a view that any treatment provided prior to hearing from the substitute decision-maker should be the least intrusive possible.

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[165] Note 136, above, s. 25.

[166] *Marshall v. Curry*, [1933] 3 D.L.R. 260 at 275 (N.S.S.C.).

[167] The Public Trustee is a government office that may be appointed, among other matters, to act as a guardian for a person who is found to be mentally incompetent. For more details about the Public Trustee, see Part III.B.7, below.

The Commission takes the position that to protect the health of patients, while at the same time upholding their right in general to consent to treatment, as well as to provide guidance and reassurance to physicians, an emergency exception concerning treatment should be included in the *Act*. The Commission is of the view that the Ontario approach to this issue reflects the common law. As a result, the Commission suggests the statute should specifically allow for treatment to be administered without consent to a person who is incapable with respect to the treatment, if there is an "emergency." An "emergency" should be found to exist if the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

The Commission suggests:

- The statute should specifically allow for treatment to be administered without consent to a person who is incapable with respect to consent to the treatment if there is an "emergency."

- An "emergency" should be found to exist if the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

5. Use of restraints

Should the use of restraints be allowed, under certain circumstances? If so, should there be an exemption of liability for health care professionals who use retraints?

A restraint can be mechanical, such as arm or leg devices, or a chemical agent, such as a sedative. The use of restraints to prevent bodily harm or to manage non-threatening behaviour is not currently addressed in the Nova Scotia legislation.

Some people object to the use of any restraints. Others, though not in favour of restraints, suggest that in certain circumstances, approaches such as the use of helmets or other special equipment, or special isolation ("tranquility quiet" or "TQ") rooms, would be appropriate. Another perspective is that restraints can never be completely avoided, as some people who are dangerous will be in need of restraint while treatment is being provided.

Health care professionals might have concerns about the consequences of improperly applying restraints. For example, if a health care professional restrains a patient in order to provide an injection, as part of emergency treatment, and the injection is later shown to have not been

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Health care professionals might have concerns about the consequences of improperly applying restraints. For example, if a health care professional restrains a patient in order to provide an injection, as part of emergency treatment, and the injection is later shown to have not been

needed, then the patient might commence a legal action for damages against the health care professional.[168]

In the *Uniform Mental Health Act,*[169] "restraint" is defined at subsection 27 as keeping a "person under control to prevent harm to the person or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the person."[170] Section 27 of the *Uniform Mental Health Act* also provides for the recording, in a person's file, of details concerning any restraints used.

The Commission is of the view that in some circumstances, the use of restraints will be required, where a person with a mental disorder presents a danger to self, other patients, or facility staff. Nonetheless, for the protection of patients and for the guidance of health care professionals, limits should be placed on the circumstances in which restraint can be applied and on the type of restraint available. The Commission approves the definition of restraint that is in the *Uniform Mental Health Act*. The Commission suggests that restraint should involve keeping a patient under control to prevent harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient.

The Commission also suggests that detailed records be kept of the type of restraint used. The details, to be made part of a patient's file, should include such information as the date and duration of restraint, the behaviour leading to the use of restraint, and in the event of chemical restraint, the type, administration, and dosage of the chemical used.

The Commission takes the position that a health care professional who properly uses restraint as part of legitimate treatment should not be liable for damages in a civil action. As a result, the Commission suggests that the *Act* should include a clause exempting from liability for the use of restraint any person acting reasonably and in good faith in the course of his or her duties under the *Act*.

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[168] One ground could be battery, which involves intentionally bringing about an offensive or harmful contact with another person: Dukelow & Nuse, note 102, above, at 89.

[169] Note 108, above.

[170] Note 108, above, s. 27(1).

The Commission suggests:

- Restraint should involve keeping a patient under control to prevent harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient.

- Detailed records should be kept of the type of restraint used. The details, to be made part of a patient's clinical record, should include such information as the date and duration of restraint, the behaviour leading to the use of restraint, and in the event of chemical restraint, the type, administration, and dosage of the chemical used.

- The *Hospitals Act* should include a clause exempting from liability for the use of restraint any person acting reasonably and in good faith in the course of his or her duties under the *Act*.

6. Advance health care directives

How should advance health care directives be treated in the *Act*?

An advance health care directive allows an adult who is mentally capable to make decisions for future medical treatment or non-treatment in anticipation of future mental incapacity. In its 1995 Final Report on adult guardianship and advance health care directives, the majority of the Law Reform Commission of Nova Scotia made a number of recommendations concerning advance health care directives.[171] The Commission recommended that the law should allow a person to set out instructions or general principles about future health care decisions. This would be in addition to allowing a person to appoint a proxy to follow instructions and interpret general principles concerning health care decisions set out in a directive or to make health care decisions on the maker's behalf. The Commission took the position that an advance health care directive should be effective whenever a person was incapable of making health care decisions. The Commission was in favour of a duty to follow the instructions contained in the directive unless there were compelling reasons for not doing so. A proxy would have a duty to act according to what he or she knew of the maker's wishes or, if unknown, according to the maker's best interests. The proxy would not be allowed to delegate

[171] Law Reform Commission of Nova Scotia, *Reform of the Laws Dealing with Adult Guardianship and Personal Health Care Decisions* (Final Report) (Halifax, N.S.: The Commission, 1995) at iii-iv.

The Commission suggests:

- Restraint should involve keeping a patient under control to prevent harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient.

- Detailed records should be kept of the type of restraint used. The details, to be made part of a patient's clinical record, should include such information as the date and duration of restraint, the behaviour leading to the use of restraint, and in the event of chemical restraint, the type, administration, and dosage of the chemical used.

- The *Hospitals Act* should include a clause exempting from liability for the use of restraint any person acting reasonably and in good faith in the course of his or her duties under the *Act*.

6. Advance health care directives

How should advance health care directives be treated in the *Act*?

An advance health care directive allows an adult who is mentally capable to make decisions for future medical treatment or non-treatment in anticipation of future mental incapacity. In its 1995 Final Report on adult guardianship and advance health care directives, the majority of the Law Reform Commission of Nova Scotia made a number of recommendations concerning advance health care directives.[171] The Commission recommended that the law should allow a person to set out instructions or general principles about future health care decisions. This would be in addition to allowing a person to appoint a proxy to follow instructions and interpret general principles concerning health care decisions set out in a directive or to make health care decisions on the maker's behalf. The Commission took the position that an advance health care directive should be effective whenever a person was incapable of making health care decisions. The Commission was in favour of a duty to follow the instructions contained in the directive unless there were compelling reasons for not doing so. A proxy would have a duty to act according to what he or she knew of the maker's wishes or, if unknown, according to the maker's best interests. The proxy would not be allowed to delegate

[171] Law Reform Commission of Nova Scotia, *Reform of the Laws Dealing with Adult Guardianship and Personal Health Care Decisions* (Final Report) (Halifax, N.S.: The Commission, 1995) at iii-iv.

decision-making authority to another person, and there would be limits on what a proxy could consent to on behalf of the maker unless specifically authorized.

The current Nova Scotia law on advance health care directives, which is found in the *Medical Consent Act*,[172] only refers to proxies. An advance health care directive which uses instructions is not expressly allowed under Nova Scotia law. The rest of this section, however, pertains only to instructional directives and would require implementation of the Commission's 1995 report before being relevant to the *Hospitals Act*.

Some people are of the view that it should be possible not to follow an advance health care directive, even if its instructions are clearly set out, in certain circumstances. These people believe that legislation should include reference to advance health care directives and indicate when it would be appropriate for proxies and physicians not to comply with an advance health care directive. Sometimes this is referred to as a statutory "override." The need for guidance about advance health care directives is acute for physicians, who have sworn to preserve life and health. This could lead to difficult choices.

The majority of the Commission acknowledges that for the most part, people should be able to make their own decisions concerning their personal health. It is possible, though, that a person's instructions about future health care lack clarity or comprehensiveness. For example, an advance health care directive may fail to address a particular situation. Moreover, an advance health care directive may have been created at a time when certain procedures or treatment were not available. Had the maker of the advance health care directive known about certain medical innovations, his or her instructions may have been different. The majority of the Commission affirms that a person who is mentally capable can refuse all treatment. However, the majority of the Commission also takes the position that where a person is no longer mentally capable, certain circumstances justify not following an advance health care directive. The majority of the Commission suggests that it may be possible not to follow an advance health care directive in light of medical developments not available at the time the advance health care directive was created. The Commission invites suggestions about what other compelling circumstances might justify not following an advance health care directive.

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[172] Note 152, above.

The majority of the Commission suggests:

- Where a person is no longer mentally capable, certain compelling circumstances, such as medical developments not available at the time an advance health care directive was created, may justify not following the advance health care directive.

The Commission invites comments on:

- What other compelling circumstances might justify not following an advance health care directive.

7. Office of Public Trustee

Should the role of the Public Trustee with respect to consent to treatment be revised?

The Public Trustee is a government office that may be appointed to, among other matters, act as a guardian for a person who is found to be mentally incompetent. The *Hospitals Act* specifically mentions a number of powers or responsibilities of the Public Trustee involving persons civilly committed to a facility.[173] According to subsections 54(2) and 60(2), the Public Trustee can provide consent for a proposed treatment when a patient is not capable of making a treatment choice and when the patient does not have a guardian, spouse or next-of-kin to give consent on the patient's behalf.[174]

Some people believe that if the Public Trustee is to continue to have a role in treatment decisions, then sufficient statutory direction and guidance should be provided. Other people have questioned whether the Office of Public Trustee is the most appropriate body to give consent on behalf of persons not capable of consenting to treatment decisions. These people have asked who will monitor the appropriateness of the Public Trustee's decisions.

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[173] Depending on the context, the Public Trustee may be involved under the *Hospitals Act*, note 51, above, in applying for the discharge of a person [s. 47], providing consent to treatment [ss. 54 and 60], applying for a review of a capacity or competency declaration [s. 58], intervening to preserve and protect the property of a person subject to a competency declaration [s. 59] and providing consent to the disclosure of a person's hospital records [s. 71].

[174] Section 54(2), note 51, above, also allows the Public Trustee to provide consent for treatment "where the spouse or next-of-kin is not available or consent is unable to be obtained." During the 1998 to 1999 fiscal year, 29 medical consents were sought from the Public Trustee: Nova Scotia, Office of Public Trustee, *Annual Report for Fiscal Year Ending March 31, 1999* ([Halifax: The Office, 1999]) at 22. In the previous four years, there were 13, 18, 19, and 23 applications, respectively.

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The Commission notes that the Public Trustee's ability to consent to treatment extends beyond mental health questions. For instance, the Public Trustee might be asked to provide consent for a dental procedure involving a person who is not mentally capable, but who does not have a mental illness. The Commission is of the view that the Public Trustee's role in relation to consent to treatment could best be considered as part of a separate project examining all the duties and responsibilities of the Public Trustee. Such a project could examine such other health-related issues as whether the Public Trustee could be required to intervene in treatment decisions and whether the Public Trustee staff should include people with medical training.[175]

The Commission suggests:

- The Public Trustee's role in relation to consent to treatment could best be considered as part of a project examining all the duties and responsibilities of the Public Trustee.

8. Provision of mental health treatment in the community: "community treatment orders" and "leave certificates"

In certain circumstances, should there be compulsory treatment in the community for involuntary patients?

Not all involuntary patients in Canada remain confined to a facility while they are receiving treatment. As an alternative, some patients are permitted to live in the community, so long as they follow a treatment schedule and other conditions. For instance, a patient might have to prove that he or she continues to take prescribed medication. The programs whereby involuntary patients can return to the community have been compared to a type of parole. If patients do not respect the conditions of the program, they can be committed once again to a facility. The guidelines for the return of involuntary patients to the community are known as "community treatment orders" or "leave certificates." A community treatment order is a legal mechanism which provides for the compulsory treatment of a patient who lives in the community, subject to a number of conditions and restrictions.[176] Leave certificates are similar, in that they allow involuntary patients to return to the community and receive

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[175] The Public Trustee's role in relation to the finances and property of patients is discussed at Part III.C, below.

[176] Manitoba, Department of Health, Mental Health Act Review Committee, *Potential Amendments to the Mental Health Act* (N.p.: [Minister of Health], 1996) at 17.

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treatment there. Unlike community treatment orders, leave certificates involve treatment plans to which a patient or the patient's representative has consented.[177]

In Nova Scotia, the law does not provide for community treatment orders or leave certificates. Physicians are restricted to providing treatment for involuntary patients in an in-patient hospital setting. Saskatchewan is presently the only jurisdiction in Canada which allows for the involuntary treatment in the community of persons with mental illness. However, community treatment with some compulsory aspect is in place in Manitoba,[178] British Columbia,[179] and Prince Edward Island,[180] and will soon be in effect in Ontario.[181] New Brunswick has also recently considered compulsory community treatment.[182]

What sets the Saskatchewan legislation apart from other community treatment schemes is its mandatory nature. Saskatchewan's community treatment orders apply to involuntary patients who are unable to fully understand and to make an informed decision about their need for treatment or care and supervision. Otherwise, the community treatment details in Saskatchewan are similar to those in Manitoba.

Manitoba legislation provides for the treatment of patients with mental disorders under "leave certificates."[183] A leave certificate is meant to provide a patient with psychiatric treatment that is less restrictive and less intrusive to the patient than being detained in a facility. The leave certificate allows a patient or the patient's representative to consent to a treatment plan proposed under such a certificate. A leave certificate may be issued if a patient: during the previous two years, has been a patient in a facility for at least 60 days; has been a patient in a facility on three or more separate occasions; or has been the subject of a previous leave certificate. A treatment plan must be developed, and the patient is entitled to participate in the

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[177] See, for example, Manitoba statute, note 99, above, s. 46.

[178] Note 99, above, ss. 46-48.

[179] B.C. statute, note 93, above.

[180] P.E.I. statute, note 96, above, s. 25.

[181] *Brian's Law*, note 117, above, ss. 15-17. A recent United Kingdom consultation paper has also made recommendations for compulsory community care and treatment: U.K., H.C., "Reform of the Mental Health Act 1983: Proposals for Consultation" Cm 4480 (1999) at 37-39.

[182] New Brunswick recently undertook a consultation process with 80 stakeholders to consider the implementation of community treatment and outpatient committal options. A decision was made to use the "extended leave" provisions already provided for in its *Mental Health Act*; to strengthen proactive community treatment programs; and to provide more education about the current law. [Telephone conversation with Mr. Luc Doucet, Chief Patient Advocate for New Brunswick (7 July 1999)].

[183] Note 99, above, ss. 46-48.

plan's development. The patient or the patient's representative must consent to the treatment plan in order for a leave certificate to be issued. Criteria for issuing a leave certificate also include:

- the person must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community;
- the patient is likely, because of the mental disorder, to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration if the patient does not receive continuing treatment or care and supervision while living in the community;
- the patient is capable of complying with the leave certificate requirements; and
- the treatment or care and supervision described in the leave certificate exists in the community and can and will be provided in the community.

Although Manitoba leave certificates are issued to involuntary patients, a patient for whom a leave certificate is issued acquires the status of voluntary patient. A leave certificate can be reviewed. A certificate can also be cancelled if a psychiatrist believes, on reasonable grounds, that a patient could be a danger.

Prince Edward Island legislation allows for the treatment of involuntary patients in the community under a "certificate of leave," issued by the attending psychiatrist of an involuntary patient. The patient is thereby allowed to live outside the psychiatric facility subject to the requirement to report at specified times and places for treatment and to any other conditions specified in the certificate. The patient must also consent to the leave certificate.[184]

People who support community treatment orders or leave certificates consider them to be less restrictive and less intrusive than involuntary hospitalization. They suggest that people under this treatment option can lead more normal lives and readjust to society more quickly than if confined to hospital. It has been described as particularly appropriate for those patients who have repeatedly shown that they are unable to comply with treatment on a voluntary, outpatient basis. Such patients, if affected by chronic mental illness, might repeatedly return to hospital, with deterioration in their mental state at the time of each new admission. Those in favour of community treatment orders and similar programs believe that they would not affect a large number of patients.

Opponents of this treatment option consider it to be an unjustified intrusion on a person's civil liberties. They consider current legislation to contain enough power for the state to force treatment upon individuals and express the concern that community treatment orders might affect a much larger number of people than imagined. Rather than spending money on

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[184] Note 180, above.

monitoring patients in the community, opponents of this treatment approach would prefer that funds be spent on support programs in the community for people with mental illness.

As with many of the questions involving the *Hospitals Act*, there appears to be a conflict of values in relation to this issue. On balance, the Commission is of the view that it would be more helpful than not to allow for the possibility of treatment in the community. This treatment option can free certain patients from the intrusiveness of compulsory hospitalization and allow them the opportunity to assume more normal lives in the community. As this approach involves a continuity of treatment, it can help to avoid the cycle of patients who continue to be discharged from a facility, only to return, with a deterioration in their mental state, when they do not adhere to their treatment schedule. The Commission is also of the view that community treatment approaches are more conducive to allowing patients to participate in determining the nature of their treatment. This participation might increase the chance that patients will adhere to their treatment plan.

The Commission supports the implementation of a program of leave certificates as was devised in Manitoba. In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. Consistent with earlier suggestions about the criteria for civil commitment (Parts III.A.3a) and b), above), the patient must be considered likely, because of the mental disorder, to cause bodily harm to self or others, to cause psychological harm to self, or to suffer imminent and serious impairment if the patient does not receive continuing treatment or care and supervision while living in the community. A collaborative treatment plan must be developed, to which the patient or the patient's representative consents. The patient must be capable of complying with the leave certificate requirements. The treatment or care and supervision described in the leave certificate must exist in the community and can and will be provided in the community.[185]

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[185] The Commission is of the view that the creation of a leave certificate program should not be used as an excuse to reduce the budget for medication which is currently funded by Government on behalf of those people committed to facilities.

The Commission suggests:

- Leave certificates should be made available in Nova Scotia for certain involuntary patients.

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C. PATIENTS' PROPERTY AND FINANCES

1. Mental competence to administer one's estate

Issues similar to those raised by the capacity to consent to treatment provisions (Part III.B.1, above) are also raised by the competency sections of the *Hospitals Act*.

a) Competency determination

When should a competency determination be done?

An estate is everything that a person owns. Subsection 53(3) of the *Hospitals Act* requires a declaration of competency to administer one's estate to be made when a person is admitted to a facility. Although the *Act* requires a determination of a person's capacity to consent to treatment to be done within three days of admission, the precise timing of determining one's competency to administer one's estate is not specified.

An issue is whether there should be a mandatory assessment, or if a competency determination should be done only if there is concern about a person's competency to manage his or her financial affairs. The majority of Canadian provincial and territorial jurisdictions, including

Nova Scotia, provide for a competency assessment upon admission of a person to a psychiatric facility.

Some believe that as a matter of convenience, there should be a mandatory competency determination upon a person's admission to a facility. Others agree that though a competency determination could prove useful, it should only be done when required. To do otherwise, they suggest, would be contrary to the common law's presumption of competency until the contrary is established. It has also been suggested that there should be a possibility of having competency determinations reviewed.

The Commission is of the view that given the common law presumption of competency in relation to one's estate, then the current statute, by requiring a competency determination upon a person's admission to a facility, is inconsistent. By eliminating the need for discretion, having an automatic competency determination might prevent certain problems. In some cases, though, it would be an unnecessary intrusion into a patient's private affairs. One way of dealing with the need for competency determinations would be to allow them when a psychiatrist, during the course of completing a capacity assessment, believed there was also a need for an assessment relating to competency to administer one's estate. Consistent with its suggestion in relation to capacity determinations (Part III.B.1, above), the Commission suggests that a competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

The Commission suggests:

- A competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

b) Factors for competency determination

Should the current factors for determining a person's competency be revised?

The test to determine one's competency to administer one's financial affairs is similar to the test to determine one's capacity to consent to treatment. The factors for determining a person's competency are set out at subsection 52(3) of the *Hospitals Act* and require the psychiatrist to consider:

a) the nature and degree of the person's condition;
b) the complexity of the estate;
c) the effect of the condition of the person upon his [or her] conduct in administering his [or her] estate; and

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b) the complexity of the estate;
c) the effect of the condition of the person upon his [or her] conduct in administering his [or her] estate; and

d) any other circumstances the psychiatrist considers relevant to the estate and the person and his [or her] condition.

The Commission is of the view that the wording of subsection 52(3) is a good combination of specific terms and flexible wording. In particular, clause 52(3)(d), by referring to "any other circumstances," frees the statute from having to identify all other possibly relevant factors that might arise. The Commission suggests that subsection 52(3), which sets out the factors to be considered in determining a person's competency to administer his or her estate, should remain unchanged.

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- The factors to be considered in determining a person's competency to administer his or her estate should remain unchanged.

c) Competency assessors

Who should perform competency assessments?

Psychiatrists currently complete competency determinations under the *Hospitals Act*. Some people have suggested that such a decision should more properly be made by a review board, whose members include people without psychiatric training.

Using the same justification as it did in relation to capacity assessments (Part III.B.1c), above), the Commission takes the position that suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

The Commission suggests:

- In addition to psychiatrists, suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

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2. Office of Public Trustee

Should the role of the Public Trustee concerning management of patients' estates be revised?

With respect to management of a person's estate, section 59 of the *Hospitals Act* creates a mechanism whereby the Public Trustee, being notified by a hospital to do so, may "assume management" of the estate of a patient who has no guardian, and who is unable to administer his or her own estate. This referral mechanism continues to be the source of much of the Public Trustee's caseload.[186]

The Public Trustee's intervention is not compulsory in relation to property matters. Like any other estate supervisor, the Public Trustee's office is paid a fee. This fee is paid for from estate assets and varies according to the amount managed.[187]

One perspective is that the role of the Public Trustee is essential, to ensure there is at least one representative with the ability, on an interim basis, to protect and preserve the assets of a person who is in a facility. Some time might pass before family, friends, or others become concerned about a person's absence. In the meantime, bills, loans, and mortgages need to be paid, and property must be maintained or protected. In some cases, there may not be anyone apart from the Public Trustee to tend to a person's property and finances.

Of those people in favour of retaining the Public Trustee's role in overseeing the estates of people in facilities, some believe there should be mandatory intervention of the Public Trustee in certain situations. Others suggest that it is important to retain discretion about whether to intervene, in order to take into account such factors as budgetary and staffing requirements, as well as the availability of relevant information.

From the Commission's perspective, the Public Trustee's role in the mental health system is a significant one. Concerning the protection of estates, the Commission is concerned that allowing the Public Trustee discretion about whether to intervene might mean that some estates of patients in facilities are left without proper supervision. The Commission is also concerned that in an attempt to meet its operating costs, the Office of Public Trustee might choose to intervene only when an estate's value is large enough to meet the costs of the Public Trustee's work. The Commission takes the position that involvement of the Public Trustee in relation to the estates of patients in facilities should not be determined merely by finances. Given the

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[186] According to the Public Trustee's 1998-1999 Annual Report, of the 43 new adults' estates (living), 18 originated from a "Section 59" referral: note 174, above, at 3. It should also be noted that the *Powers of Attorney Act*, R.S.N.S. 1989, c. 352 allows for people to avoid the effect of s. 59 of the *Hospitals Act*, by specifying that the attorney and not the Public Trustee is to conduct the administration of the person's estate.

[187] The fees are based on a scale suggested by the Supreme Court of Nova Scotia: note 174, above, at 7.

important public service provided by the Public Trustee's Office, its value should not be measured only by whether it can meet its expenses. As a result, the Commission suggests that when the estate of a patient in a facility is in need of supervision and no other person is available, intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role without worrying about the ability of some estates to pay.

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D. REVIEW AND APPEAL

1. Composition of review boards

Should the composition of review boards be defined?

To "review" a decision is to reconsider it. Section 61 of the *Hospitals Act* allows the provincial Cabinet to appoint persons to be members of a review board for one or more facilities. The board is known as the Psychiatric Facilities Review Board. In order for a review board to hold a hearing, a minimum of three members (a "quorum") is required.[188] Unlike legislation in some other Canadian jurisdictions, the *Hospitals Act* does not define the composition of a review board. By contrast, the British Columbia *Mental Health Act* provides for review boards consisting of a chair, a physician appointed by the treating facility, and a person, other than the patient or a member of the patient's family, who is appointed by the patient.[189] The Nova Scotia *Act* does indicate, however, that no member shall sit on a review board considering the review of a patient, client, or relative of that member. In practice, a review board is usually comprised of a lawyer, a psychiatrist and another non-lawyer, with the lawyer acting as chair.

Some people believe that the involvement of a psychiatrist on a review board is not necessary, so long as a member of the mental health team involved in patient treatment is present. Others

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[188] Note 51, above, s. 62.

[189] Note 93, above, s. 25(5).

suggest that given the knowledge and experience of psychiatrists, their participation is essential. Concerning the appointment of individuals who are neither lawyers nor psychiatrists, one view is that preference should be given to mental health consumers.[190] It has also been pointed out, however, that this could be unduly intrusive, requiring disclosure in part of a consumer's mental health history and to what extent he or she received certain services.

The Commission is of the view that in relation to the composition of a review board, the current wording of the *Act* should remain unchanged. The flexibility of the current review board provisions would be diminished if the *Act* required every review board to include a representative from a certain group. The Commission is also concerned that to insist upon representatives from certain groups could make the statute more complicated in content and more difficult to apply. For example, it could prove difficult to define what nature and extent of mental health services would be required to qualify someone as a "mental health consumer" for the purpose of serving on the board. The Commission therefore suggests that the composition of a review board need not be defined in the *Act*.

Although the Commission considers flexibility to be a strength in relation to review board composition, the Commission is also aware of the need among review board members for a minimum level of information about the responsibilities involved with their appointments. The Commission refers to its Final Report on reform of the administrative justice system and affirms the recommendation that training be provided for all review board appointees.[191] Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

The Commission suggests:

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[190] A mental health consumer is a person who, because of a mental health problem, uses or at some point used, mental health services: Nova Scotia, Minister of Health, Minister's Action Committee on Health Care Reform, *Achieving Health for All: The Mental Health Component* (N.p.: [Dept. of Health,] 1994) at 44.

[191] Law Reform Commission of Nova Scotia, *Reform of the Administrative Justice System in Nova Scotia*, Final Report (Halifax: The Commission, 1997) at 45.

important public service provided by the Public Trustee's Office, its value should not be measured only by whether it can meet its expenses. As a result, the Commission suggests that when the estate of a patient in a facility is in need of supervision and no other person is available, intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role without worrying about the ability of some estates to pay.

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D. REVIEW AND APPEAL

1. Composition of review boards

Should the composition of review boards be defined?

To "review" a decision is to reconsider it. Section 61 of the *Hospitals Act* allows the provincial Cabinet to appoint persons to be members of a review board for one or more facilities. The board is known as the Psychiatric Facilities Review Board. In order for a review board to hold a hearing, a minimum of three members (a "quorum") is required.[188] Unlike legislation in some other Canadian jurisdictions, the *Hospitals Act* does not define the composition of a review board. By contrast, the British Columbia *Mental Health Act* provides for review boards consisting of a chair, a physician appointed by the treating facility, and a person, other than the patient or a member of the patient's family, who is appointed by the patient.[189] The Nova Scotia *Act* does indicate, however, that no member shall sit on a review board considering the review of a patient, client, or relative of that member. In practice, a review board is usually comprised of a lawyer, a psychiatrist and another non-lawyer, with the lawyer acting as chair.

Some people believe that the involvement of a psychiatrist on a review board is not necessary, so long as a member of the mental health team involved in patient treatment is present. Others

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[188] Note 51, above, s. 62.

[189] Note 93, above, s. 25(5).

suggest that given the knowledge and experience of psychiatrists, their participation is essential. Concerning the appointment of individuals who are neither lawyers nor psychiatrists, one view is that preference should be given to mental health consumers.[190] It has also been pointed out, however, that this could be unduly intrusive, requiring disclosure in part of a consumer's mental health history and to what extent he or she received certain services.

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2. Review applications

a) Applicants

Who can apply for a review hearing?

The main function of a review board is to review the involuntary status of patients detained in psychiatric facilities. Since voluntary patients are not officially detained and are able to leave a facility if they choose, most provincial and territorial mental health statutes do not provide voluntary patients with a right of review.[192]

In Nova Scotia, the list of those who can request a review of a patient's file, and therefore a review hearing, is set out at subsection 65(1) of the *Hospitals Act*:

> *a) the patient;*
> *b) a person, other than another patient, authorized by the patient to act on his [or her] behalf;*
> *c) the administrator of the facility where the person is a patient;*
> *d) the medical director of the facility where the person is a patient;*
> *e) the administrator of psychiatric mental health services; or*
> *f) the Minister.*

Approaches differ in the rest of Canada as to who can request a review hearing. For example, in Alberta, the patient or a representative may apply to a review board for cancellation of an admission or renewal certificate.[193] In New Brunswick, a person who questions the opinion of the attending psychiatrist in making a declaration of competence may apply for a review.[194] The Yukon *Mental Health Act* provides that an application for review can be made by "any person having a substantial interest in the subject matter of the review application."[195]

The Commission is of the view that for the most part, the list at subsection 65(1) of the Nova Scotia statute of those entitled to apply for a review hearing is satisfactory. Although it lacks specificity to some extent, this is compensated in part by its flexibility. The Commission notes

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[192] The Ontario and British Columbia statutes, however, allow for the review of a voluntary patient's admission if that patient was admitted to the facility on the authority of a parent or guardian. According to British Columbia law, a voluntary patient under the age of 16 can apply to the review panel for a review of his or her admission: B.C. statute, note 93, s. 21. In Ontario, the relevant legislation provides for the review of admissions of children between the ages of 12 and 16: Ontario statute, note 100, above, s. 13.

[193] Alberta statute, note 93, above, s. 38.

[194] N.B. statute, note 96, above, s. 8.5.

[195] Yukon statute, note 97, above, s. 31.

that subsection 65(1) does not specifically refer to applications by substitute decision-makers, appointed by a patient to act on the patient's behalf. Nonetheless, clause 65(1)(b), which refers to "a person, other than another patient, authorized by the patient to act on his behalf" should be wide enough to take substitute decision-makers into account. Consistent with the current mental health system, the Commission points out that at clause 65(1)(e), the wording should be changed to take into account the fact there is no "administrator of psychiatric services."

The Commission also notes that some minors, though under the legislated age of majority, may be mature enough to understand the nature and consequences of medical treatment. If the parents or guardian of these patients lack initiative or disagree with the need for review, then these minors might be deprived of a review. As a result, the Commission suggests that a patient under the legislated age of majority should also be able to apply for a review.

The Commission suggests:

- For the most part, the list at subsection 65(1) of the *Act* of those who can request a review of a patient's file should remain unchanged. The wording should be amended, though, to take into account the fact that there is no "administrator of psychiatric services."
- A patient under the legislated age of majority should also be able to apply for a review.

b) Review board decisions

Should a decision of the review board be binding on the parties?

Section 63 of the *Hospitals Act* sets out what matters can be heard by a review board in Nova Scotia. It includes declarations of formal admission, requirements for psychosurgery, and declarations of capacity and competency. In relation to these issues, a review decision is binding.

A review board is also able to provide recommendations respecting the treatment or care of a patient. These recommendations, however, are not binding on the parties. In some other jurisdictions, such as Prince Edward Island,[196] the orders of review boards are binding on the parties.

[196] P.E.I. statute, note 96, above, s. 29.

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Perspectives differ on the ideal role of a review board. In relation to treatment and care, some people would like the review board to have the power to make a binding order, rather than simply a recommendation. Others are concerned that it would not be appropriate for non-medical people to have the power to influence treatment decisions. Health care professionals, for instance, may be reluctant to put into effect a board order about treatment when not all of the board members had a medical background.

Where treatment is in issue, the Commission takes the position that the opinion of the treating psychiatrist should be given a great amount of deference. In general, it would not be appropriate for a review board, even one which included a psychiatrist, to substitute its opinion on treatment for that provided by a mental health care professional who was able to take sufficient time to assess a patient and monitor any changes in his or her condition. The Commission is also concerned that if a review board could provide an order about treatment, the review process would become unduly delayed by applications for review. As a result, the Commission suggests that in relation to treatment and care, review boards for the most part should continue to provide only non-binding recommendations. In this way, the review board would continue to have some input into treatment issues, but would generally defer to those who have necessary training and who have spent sufficient time with a patient. Consistent with an earlier suggestion, at Part III.B.3a), above, a review board should, however, be able to approve compulsory treatment for a person who has not appointed a proxy through an advance health care directive and who has become mentally incapable. Also, following the suggestion at Part III.B.3b), above, a review board would have to approve extraordinary types of treatment.

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3. Limitation on frequency of review applications

Should the current limit on the frequency of review applications be maintained?

Most provinces and territories impose restrictions on the number of times in a given period that a patient may apply for a review hearing. These restrictions usually take the form of limiting the patient to one application for each new admission or renewal certificate. In Nova Scotia, subsection 65(2) of the *Hospitals Act* provides that a review board may refuse a

patient's request for a hearing if the patient's file has been reviewed in the previous six months.

The Commission takes the position that in the interest of fairness to patients, and consistent with a suggestion earlier in the Discussion Paper, in relation to renewal certificates (Part III. A.6b), above) the limit on the frequency of review applications should be shortened to three months.

The Commission suggests:

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4. Timing of hearing a review application

Should the current time frames for hearing a review application be maintained?

Subsection 65(1) of the *Hospitals Act* requires a review board to hear a review application within one month of the request. This time frame tends to be longer than the time frames provided by other Canadian mental health statutes. For instance, in Alberta, a review panel must hear a request as soon as it is able to do so and in any case within 21 days.[197] In Ontario the review board must generally hear the application within seven days of receipt, and in Saskatchewan, a review panel must give its decision within three business days of receiving the application.[198]

The Commission takes note of a concern that if an application for review is not dealt with expeditiously, then ultimately the review process may prove to be of diminished or of no value to some patients. For example, because of undue delays, a patient's commitment certificate might expire and not be reviewed before a review hearing is held on the issue of that person's involuntary status. A patient might end up remaining longer in a facility than would have been the case had a review board examined the situation. It should not be overlooked that involuntary commitment of patients and other *Hospitals Act* decisions involve a significant infringement of people's personal freedom. As a result, the Commission is in favour of shortening the time frame for the hearing of a review application. The Commission also acknowledges, however, that after notice of an application for review is provided, a certain amount of time is necessary in order for the facility to provide copies of documents for the

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[197] Alberta statute, note 93, above, s. 40.

[198] Ontario statute, note 100, above, s. 44; Saskatchewan statute, note 125, above, s. 34.

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5. Mandatory reviews

Should the current mandatory review hearings be maintained?

In some Canadian jurisdictions, as for example, in British Columbia,[199] a patient or the patient's representative is required to initiate the review process. It has been pointed out that in certain circumstances, this may be less than satisfactory. A patient may not be aware of his or her rights, or may not be able to assert them. A patient's representative could similarly lack knowledge or an ability to assert a position. There is also the possibility that the efforts of a patient's representative, such as a relative, had led to the patient's commitment. The patient's representative might therefore be reluctant to vigorously assert the patient's rights.[200]

To help prevent the situation of a patient unable to assert his or her right to a review, in some provinces, mandatory periodic review of patients' files is required. For example, in Nova Scotia, the review board is required to review the file of every involuntary patient once every six months for the first two years and then once a year thereafter.[201]

The Commission is of the view that mandatory, periodic reviews of a patient's file are an important safeguard of a patient's rights. Mandatory reviews can help to protect a patient who, because of a lack of knowledge, initiative, or from additional factors, would not otherwise assert his or her right to a file review. Similar factors might affect a patient's representative. The Commission takes the position that the average length of time between

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[199] B.C. statute, note 93, above, s. 25.

[200] Note 105, above, at 29.

[201] Note 51, above, s. 64.

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6. Procedure at review board hearings

a) Duty to hold a hearing

Should there be a duty for a review board to hold a hearing?

In Nova Scotia, section 66 of the *Hospitals Act* requires a hearing to be held if the review board receives a request for a hearing by any person authorized to do so. It does not, however, specify that an oral hearing is required. In most other Canadian jurisdictions, the review board is required to hold a hearing to consider the application for review. By contrast, in New Brunswick, the review board is under no statutory duty to hold a hearing,[202] though it may hold a hearing for the purpose of receiving oral testimony.

In order to ensure that the review process is fair and open, and to facilitate the presentation of as much relevant information as possible, the Commission takes the position that an oral hearing should be held whenever a review board considers an application for review.

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b) Attendance at hearing

Who should be able to attend a review hearing?

When a review hearing is to be held, it must be decided who is entitled to receive notice of the hearing and who can attend. In order to protect the privacy of patients and to ensure that only relevant information is presented to the board, restrictions are placed on who is entitled to attend a hearing. In Nova Scotia, members of the public are excluded from a hearing unless requested to attend by the patient or the patient's representative.[203] Notice of a hearing is to be given to the patient or the patient's representative, to the administrator of the facility where the patient is located, and to any other person who requested a hearing where that person is not otherwise entitled to receive notice.[204] The *Hospitals Act* at subsection 65(5) also expressly provides a patient or the patient's representative with the right to attend a hearing and to be heard.

Although a patient and the health care facility with responsibility for that patient have an obvious interest in a hearing, perspectives differ as to who else should be entitled to attend. For example, some people believe family members should be given notice of a review application. Family members might be of the view that continuing treatment for an involuntary patient would be in the patient's best interest. Where a patient exhibited violent behaviour towards relatives in the past, family members might wish to express a concern that the discharge of the patient could place them in danger. It could be argued, though, that family members may not always have a patient's best interests in mind and should therefore not be entitled to attend a review hearing.

Viewpoints also differ about whether the *Act* should specify what groups of people are entitled to attend a hearing, or whether more general, and therefore more flexible, language should be used. If the latter option was used, then anyone apart from the patient and the mental health care facility might have to apply for the review board's permission to attend.

The Commission prefers the flexibility associated with a general provision relating to people entitled to attend a hearing. A general provision can accommodate the variety of situations and relationships which could lead to a person or institution having a legitimate interest in a review application. The Commission is of the view that it would be too difficult to attempt to predict all people who might have such a legitimate interest. As a result, the Commission suggests that the *Act* should define in a general fashion who may attend a review hearing. The review board should have the discretion to determine whether a person has the necessary or legitimate

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[203] Note 51, above, s. 66(8).

[204] Note 51, above, s. 66(3).

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To help protect the interests of minors, the Commission also suggests that when a review hearing will involve a minor, notice should be sent not only to the minor, but also to the minor's parents or guardian.

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c) Refusal to hold a hearing

Are there circumstances when a review board may refuse to hold a hearing?

The Alberta *Mental Health Act* permits a review panel to refuse to hear an application if the application is "frivolous, vexatious or not made in good faith," or if there has been no significant change in circumstances since the previous hearing by the review panel.[205] The Newfoundland *Mental Health Act* contains a similar provision.[206] Mental health laws in the other Canadian provinces and territories, including Nova Scotia, are silent on this issue.

It may not be possible to gauge the merits of a review application until all of the information in support of the application is presented. What constitutes, for example, a "frivolous" application may not be known until the actual hearing. The Commission takes the position that the review process would be made more clear to all involved and easier to apply if refusals to hold a hearing are based on objective factors alone. The Commission therefore suggests that a review board may refuse to hold a hearing if a previous application by the same patient was made too recently. Consistent with an earlier suggestion about the frequency of review applications (Part III.D.3, above) three months should elapse between reviews requested by a patient.

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[205] Alberta statute, note 93, above, s. 38.

[206] Newfoundland statute, note 101, above, s. 17.

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The Alberta *Mental Health Act* permits a review panel to refuse to hear an application if the application is "frivolous, vexatious or not made in good faith," or if there has been no significant change in circumstances since the previous hearing by the review panel.[205] The Newfoundland *Mental Health Act* contains a similar provision.[206] Mental health laws in the other Canadian provinces and territories, including Nova Scotia, are silent on this issue.

It may not be possible to gauge the merits of a review application until all of the information in support of the application is presented. What constitutes, for example, a "frivolous" application may not be known until the actual hearing. The Commission takes the position that the review process would be made more clear to all involved and easier to apply if refusals to hold a hearing are based on objective factors alone. The Commission therefore suggests that a review board may refuse to hold a hearing if a previous application by the same patient was made too recently. Consistent with an earlier suggestion about the frequency of review applications (Part III.D.3, above) three months should elapse between reviews requested by a patient.

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[205] Alberta statute, note 93, above, s. 38.

[206] Newfoundland statute, note 101, above, s. 17.

The Commission suggests:

- A review board may refuse to hold a hearing if a previous application by the same patient was made too recently. Three months should have to elapse between reviews requested by a patient.

d) Protection against bias

Can a review board member sit on a review hearing if he or she has taken part in a previous hearing involving the same patient?

Some people believe it would not be fair for a review board member to participate in a hearing if he or she has already sat on a review board involving the same patient. There is concern that such a review board member may, whether consciously or not, allow preconceptions to bias his or her consideration of the matters under review in a current hearing. It has also been suggested that a review board member might lack independence and have a conflict of interest if affiliated with the psychiatric facility which detains a patient.

In Ontario, which seems to be the only Canadian jurisdiction to have dealt with this question, members of a review board are not entitled to take part in a hearing if they have already been involved in any investigation or consideration of the hearing's subject-matter. In *Dayday* v. *MacEwan*, the court explained that the purpose of the Ontario rule was to ensure "each review board panel holding a hearing approach the issues before it free of any influence by reason of prior involvement by any of its members in the same patient's case."[207]

The Commission points out that its suggestions elsewhere in this Discussion Paper, if adopted, would mean a system where frequent reviews involving the same patient are possible. In order to prevent a board member from sitting on a review board, if that member has already participated in a hearing involving the same patient, would require a large pool of review board members. The Commission is concerned there may not be sufficient numbers of review board candidates with the required knowledge, experience, and interest. This would particularly be the case for psychiatrists, most of whom work in the Halifax Regional Municipality. In other parts of the province, there may not be sufficient psychiatrists to satisfy a rule preventing previous participation by a review board member in a hearing involving the same patient.

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[207] (1987), 62 O.R. (2d) 588 at 593 (Dist. Ct.). See also *Young v. Houtman* (1990), 45 Admin. L.R. 30 (Ont. Dist. Ct.).

The Commission takes the position that having experienced review board members would help to ensure an effective review process. Allowing board members to participate in more than one hearing involving the same patient would contribute to an experienced board. The Commission also takes the view that given the qualifications of board members, one must have confidence in their abilities, including the ability to excuse themselves from a hearing on the ground of a potential conflict. Without such confidence, the review system would be founded on a suspect board. As a result, the Commission suggests that the law should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient. The Commission agrees with the wording of subsection 62(3), which prevents a review board member from participating in the review of a patient, client, or relative of the review board member. This provision helps to ensure that certain close relationships with a patient do not adversely influence a board member's decision, or lead to the impression that such influence exists.

The Commission suggests:

- The law should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient.

- The wording of the current *Act* at subsection 62(3), which prevents a review board member from participating in the review of a patient, client, or relative of that review board member, should remain unchanged.

e) Duty to provide written reasons

Should written reasons be included in review board decisions? Should the current time frames be maintained?

At common law a review board is under no duty to give reasons for its decision. Review boards have a statutory obligation, though, to provide written reasons for their decisions in Alberta, Manitoba, Ontario, and Yukon.[208]

In Nova Scotia a review board must provide a written decision to the parties within 14 days of a hearing.[209] Written reasons are not, however, necessary.

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[208] Alberta statute, note 93, above, s. 41(4) [applies when there is a decision not to cancel admission or renewal certificates]; Manitoba statute, note 99, above, s. 56; Ontario statute, note 100, above, s. 45; Yukon statute, note 97, above, s. 36.

[209] Note 51, above, s. 67.

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[209] Note 51, above, s. 67.

In *Future Inns Canada Inc.* v. *Labour Relations Board (NS)*,[210] the Nova Scotia Court of Appeal provided some guidance on the issue of whether review tribunals should give reasons for their decisions. The court indicated that reasons are not always necessary and gave the example of a finding clearly supported by the evidence. The court went on to explain that a tribunal should provide written reasons "wherever there are substantial issues to be resolved." When reviewing a tribunal's decision, it was important for a court to be able to decide whether the tribunal had a rational basis for its decision. If the reasonableness of a tribunal's decision could only be determined by examining the reasons which underlie a decision, and those reasons were not obvious from a review of the issues and the record of the proceedings, written reasons would be necessary.[211]

Differing views exist on the need to provide written reasons for a review board decision. Written reasons could be important to ensure that errors or irrelevant factors did not lead, in whole or in part, to a decision. If the inclusion of reasons would mean that decisions would be scrutinized in closer fashion, it has been suggested, then this could lead to better-reasoned decisions. The Commission's Final Report on administrative law recommended that administrative decision-makers should provide reasons for their decisions.[212]

On the other hand, written reasons may not be necessary where the basis for a decision is obvious. In many cases, the decision would be based on the medical evidence, and it would serve little purpose to repeat or summarize this evidence in a written decision. Summarizing medical evidence might even lead to errors. Insisting on written reasons in every instance might lead to challenges of decisions, with the reasons being questioned as inadequate, where this may not otherwise have occurred. Providing written reasons could also lengthen the review process.

To help protect patients' rights and to achieve clarity and openness in the review process, the Commission is of the view that review boards should provide written reasons for their decisions.

To attempt to achieve a balance between promoting expediency within the review system and allowing review board members adequate time to consider all the evidence, the Commission suggests that a decision should be communicated to the parties involved as soon as possible, and in any event, within 14 calendar days of the hearing.

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[210] (1997), 160 N.S.R. (2d) 241.

[211] Note 210, above, at 253.

[212] Note 191, above, at 55.

The Commission suggests:

- Review boards should provide written reasons for their decisions.
- A decision should be communicated to the parties involved as soon as possible, and in any event, within 14 calendar days of the hearing.

f) Patient as a compellable witness

Should the review board be able to compel the appearance of a patient at a hearing?

Subsection 66(6) of the *Hospitals Act* allows a review board to require a patient's appearance at a hearing. By contrast, the Newfoundland *Mental Health Act* states that a patient's attendance at a hearing is not required.[213] The legislation in many of the other provincial and territorial jurisdictions is silent on this issue.

In the view of the Commission, though a patient should be given the opportunity to attend and be heard at a review board hearing, it goes too far to require a patient's attendance. Subsection 66(6) of the *Hospitals Act* may have been motivated by a desire to ensure that a patient's point of view is represented. This need is, however, taken care of in other ways. In particular, both a patient and if applicable, the patient's representative have the right to be present at a hearing involving the patient and to be heard.[214] The Commission notes that section 7 of the *Charter* has been held to guarantee a right to silence in certain circumstances. In particular, a person whose freedom is being placed in question by judicial process must be given the choice of whether or not to speak to the authorities.[215] The Commission suggests that subsection 66(6), which permits a review board to require a patient's appearance at a hearing, should be deleted.

The Commission suggests:

- The review board should not be empowered to require a patient's appearance at a hearing.

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[213] Note 101, above, s. 17.

[214] Note 51, above, s. 66(5).

[215] See *R.* v. *Hebert*, [1990] 2 S.C.R. 151.

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7. Mandatory legal representation

Should there be mandatory legal representation for patients at review board hearings?

A facility in Nova Scotia is required to provide assistance to any patient or person under observation who wishes to contact a lawyer.[216] The Nova Scotia statute, though, does not provide for mandatory legal representation. By contrast, the *Uniform Mental Health Act* indicates that in a proceeding before a review board or on an appeal therefrom in respect of an involuntary patient of a psychiatric facility, the patient shall be deemed to have capacity to instruct a lawyer, and if the patient does not have legal representation, the review board or the court, as the case may be, may direct that legal representation be provided for him or her.[217]

Some people are of the view that for the protection of patients' rights, there should be some type of mandatory legal representation for a patient, with a patient also having the right to decline. For those patients who desire legal representation, but cannot afford it, some suggest that the province's Legal Aid program provide a lawyer. In its Final Report on adult guardianship, the Commission proposed that an adult subject to a guardianship application should have a right to be represented by a lawyer, but that it should not be mandatory that a lawyer be provided.[218]

The Commission acknowledges that an ideal system would provide legal representation at no charge to patients. Given the current financial situation and competing demands on provincial resources, a system of mandatory legal representation may not, however, be realistic. Alternatives to Legal Aid could involve legal representation being provided for patients by the Public Trustee Office or by the mental health facility to which a patient has been admitted. Once again, though, a lack of resources would likely be a problem. In relation to a facility, there might also be a concern about the lack of independence of a legal representative who is affiliated with a particular facility.

The Commission invites comments on whether patients should be entitled to mandatory legal representation at a review board hearing, and if so, how this could best be provided.

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[216] Note 51, above, s. 70(8). A recent report suggested that access by formal patients in Nova Scotia seems to be problematic at times. See Nova Scotia, Department of Health, *Mental Health: A Time for Action* ([Halifax: The Department], 2000) online: N.S. Dept. of Health Web site <http://www.gov.ns.ca/health/> (date accessed: 15 June 2000) at 27.

[217] Note 108, above, s. 38.

[218] Note 171, above, at 24.

The Commission invites comments on:

- Whether patients should be entitled to mandatory legal representation at a review board hearing, and if so, how this could best be provided.

8. Right to advocacy services

Should a right to advocacy services be included?

An advocate is someone who provides support and speaks on behalf of another. Advocates are often lawyers, but it is not necessary for an advocate to have legal training. The *Hospitals Act* does not require advocacy services to be provided to patients. Subsection 70(8) requires that the facility provide both patients and persons under observation with advice on their right to legal counsel, as well as providing assistance with contacting a lawyer. Subsection 66(7) also provides that a review board may appoint a representative to act on behalf of a patient.

The Uniform Law Conference of Canada has recommended that "patient advisors" be available for patients involuntarily detained in psychiatric facilities.[219]

Being admitted to a psychiatric facility can be a frightening and bewildering experience. The Commission is of the view that it could help put at ease those people who enter a facility if they can speak with a empathetic and knowledgeable person about what admission entails and the nature of their rights. Advice on the nature of one's rights could be important in relation to such matters as the review of a person's involuntary patient status, treatment decisions, management of finances, and access to health information.[220] In Ontario, a person fulfilling this role at a facility is known as a "rights adviser." A rights adviser is entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation.[221]

The Commission appreciates that given declining health care budgets, especially in the instance of smaller facilities, it may be difficult to justify employing someone solely as a rights adviser. The Commission notes, however, that in Ontario, rights advisers can fulfil other duties at a facility. A rights adviser is not someone involved in the direct clinical care of a patient to

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[219] Note 108, above, s. 20.

[220] A recent report on mental health services in Nova Scotia commented that it was "imperative" for involuntary patients to be well-informed of their rights: see note 216, above, at 27.

[221] R.R.O. 1990, reg. 741, s.16.

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whom the rights advice is to be given.[222] A rights adviser must be knowledgeable about rights of application to a review board, the nature and procedures of the review board, and how to obtain legal services. A rights adviser must also have effective communication skills.[223]

The Commission suggests that the *Act* should provide for a rights adviser at each psychiatric facility, with a similar role and qualifications to those in Ontario.

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E. CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

The mental health legislation of most Canadian provinces and territories includes provisions concerning accessibility, disclosure, and use of personal health information. Personal health information is gathered to facilitate the effective treatment of a patient during his or her hospitalization and in some cases, after the patient has been discharged. In general, health care professionals are obliged to keep information about their patients confidential. The understanding that private patient information will not be disclosed provides a foundation of trust to the relationship between patient and health care professional. Moreover, given the social stigma often associated with mental illness, as well as the possible vulnerability of persons with mental illness, there is a particular need to keep all mental health records confidential, unless consent for their disclosure is given by the patient or the patient's substitute decision maker, or is otherwise authorized by law.

Relevant legislation in Canada has tended to focus on health care professionals in a variety of settings. What sometimes result are varying standards of confidentiality, with both regulatory

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[222] *Brian's Law*, note 117, above, s. 1(9). In Ontario, a rights adviser also cannot be someone who provides treatment or care and supervision under a community treatment plan.

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overlap and gaps.[224] The variety of legislative responses, combined with the increasing use of health information computer data bases, have created interest in some provinces for improved legislation to strengthen and standardize confidentiality requirements among health care professionals. Manitoba created such legislation in 1997,[225] and in 1999, both Alberta and Saskatchewan enacted equivalent statutes.[226] The Canadian Medical Association has also developed a *Health Information Privacy Code* to assist physicians in their decisions about how personal health information should be collected, used and disclosed.[227]

Issues concerning the confidentiality of personal health information are complex and numerous. They include, among other things, identification and definition of different types of health information; ownership of health records; collection of health information; access, disclosure, and use of personal health information; integrity and security of health information; accountability of record keepers; and interaction of privacy legislation with health information.

This Discussion Paper is limited to the following issues related to personal health information: use, accessibility and disclosure of health records; accuracy, correction and amendment of health records; and implications for the interaction of privacy legislation with personal health records.[228]

1. Use, accessibility and disclosure of health records

It was only recently established that patients have a legal right of access to their own health records, subject to limited exceptions.[229]

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[224] D. Ferguson, "Overview of Current Law Relating to the Confidentiality of Health Care Information - What Have We Learned from Past Experience?" (1990) 10:3 Health L. Can. 200 at 202.

[225] *Personal Health Information Act*, S.M. 1997, c. 51.

[226] *Health Information Act*, S. A. 1999, c. H-4.8; *Health Information Protection Act*, S.S. 1999, c. H-0.021.

[227] Canadian Medical Association (CMA), *CMA Health Information Privacy Code*, online: CMA Web site <http://www.cma.ca/inside/policybase/1998/09-16.htm> (date accessed: 26 May 2000).

[228] Given the number and nature of issues involved, the subject of personal health information could form the basis of a separate Commission project.

[229] *McInerney v. MacDonald* (1992), 93 D.L.R. (4th) 415 (S.C.C.) [hereinafter *McInerney v. MacDonald*]. Arguments that disclosure of records would lead to unfounded lawsuits, that patients would not understand records, that health care professionals would be deterred from keeping complete and frank records, and that access could be harmful to patients were not accepted by the cou

From a patient perspective, it has been suggested that the right of full access to one's health record is essential for a number of reasons:[230]

- this information is required by the patient in order to make informed decisions regarding his or her health care;
- as health information is frequently disclosed to third parties, patients should be aware of what information is in their own records;
- access to health records fosters patient involvement in health care; and
- accuracy of the health records is facilitated by patients' access to their records.

a) Statutory right of access

Should a patient or a patient's representative have a statutory right of access to the patient's health records, including a right to examine and to copy the records?

In *McInerney* v. *MacDonald*,[231] the Supreme Court of Canada held that at common law patients have a general right of access to their own medical records. This right arises from the "fiduciary" nature of the physician-patient relationship.[232] A fiduciary relationship is one of special trust and confidence. By sharing information during the course of medical consultation, a patient is treated by the law as having entrusted this information to the physician. The patient's right of access to his or her health record, however, is not absolute. The Supreme Court acknowledged that a physician with a reasonable belief that it is not in a patient's best interests to inspect his or her medical records has discretion to deny access. This discretion must be exercised on proper principles and not in an arbitrary fashion.[233]

The common law is reflected in varying degrees in Canadian mental health and related legislation. In Nova Scotia, the *Hospitals Act* does not explicitly permit a patient to examine his or her record. Subsection 71(1) does provide, however, that a hospital record shall not be made available to any person or agency without the consent or authorization of the person or patient who is the subject of the record. A hospital is able to withhold information where this would be in the patient's best interest.[234] If the hospital refuses to make information available,

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[230] See H. Hobart, *A Legislative Proposal Addressing the Access to and Disclosure of Health Information* (LL.M. Thesis, Dalhousie University, 1995) [unpublished] at 43-45; S. Malcolmson, "Access by Patients to the Clinical Record" (1992) 13:2 Health L. Can. 160.

[231] *McInerney* v. *MacDonald*, note 229, above.

[232] Note 229, above, at 427.

[233] Note 229, above, at 427.

[234] Note 51, above, s. 71(3).

then the person requesting the records can apply to court for a determination whether and to what extent the records shall be made available.[235]

In the event of a dispute over access to records, patients may be reluctant to seek a court order, because of financial concerns, time constraints, or the potential for personal health information to be disclosed during a court proceeding.[236] Additionally, patients may not want to be perceived as troublemakers.

In contrast to Nova Scotia, the legislation in a number of provinces and territories requires a facility to take the initiative if it wishes to prevent disclosure. Prince Edward Island, New Brunswick, Ontario, Manitoba, Yukon, Nunavut, and the Northwest Territories have similar statutory schemes, seemingly based on the *Uniform Mental Health Act*. Under all of these statutes, patients have the right to examine and copy their own clinical record. If the facility wishes to deny a patient access, it must apply to the relevant review board for authority to withhold all or part of the clinical record. The review board must order disclosure unless it holds the opinion that this is likely to result in serious harm to the treatment or recovery of the person or is likely to result in serious physical or emotional harm to another person.[237]

The Commission is of the view that to promote fairness, openness, and confidence in the mental health care system, as far as possible patients should have access to their health records. Consistent with these aims, the Commission suggests that if a facility wishes to deny a patient access to his or her record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to establish why denial of access would be reasonable.

The Commission notes that it would make little sense to have a hearing on restriction of access if the facility was required to discuss openly, and therefore reveal to a patient, the nature of the information which the facility wished to keep confidential. As a result, review boards will have to develop procedures whereby the information at issue can be brought to the review board's attention and referred to without being revealed to a patient. The Commission points out, for example, that similar procedures are sometimes needed during the course of sexual assault trials, when the admissibility of details concerning a complainant's sexual history is in issue. The Commission acknowledges that this is a difficult issue, which involves conflicting values. The patient's right to have access to all information available to a decision-maker is in

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[235] Note 51, above, s. 71(4).

[236] Robertson, note 2, above, at 451-452.

[237] Note 108, above, s. 29; P.E.I. statute, note 96, s. 31; New Brunswick statute, note 96, above, s. 16.1; Ontario statute, note 100, above, s. 36; Man. statute, note 99, above, s. 34; Yukon statute, note 97, above, s. 43; N.W.T. statute (adopted in Nunavut), note 96, above, ss. 49.1, 49.2. In B.C. and Newfoundland, there is no reference to health records in their respective mental health and related statutes.

conflict with the need to prevent the disclosure of details which could prove harmful. In this context, the Commission asks for comments about what mechanisms and procedures should be adopted to accommodate both the need for openness and the need to keep certain details confidential.

The Commission suggests:

- If a facility wishes to deny a patient access to his or her record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at which the facility would have to convince the board why denial of access would be reasonable.

The Commission invites comments on:

- What mechanisms and procedures should be adopted to accommodate both the need for openness and the need to keep certain details confidential.

b) Use and disclosure

Should there be limits on the use and disclosure of a patient's health information?

Section 71 of the *Hospitals Act* sets out guidelines concerning the confidentiality and disclosure of health information. Section 71 is similar to provisions in the relevant legislation of other Canadian provinces and territories. It specifies that the records and hospital particulars relating to a patient or former patient are confidential and are not to be made available to others without the consent of the patient or someone else on the patient's behalf, namely a guardian, spouse, next of kin, or the Public Trustee.

Health care professionals might assume that a person has implicitly consented for his or her health information to be released to immediate family members and loved ones. A patient, however, may have compelling reasons for insisting on strict confidentiality. These could include shame, a fear of adverse reactions from family members and loved ones, or a desire to shield family members and loved ones from undue worry.[238] Subsection 71(7), to a limited extent, addresses potential concerns of third parties. It allows a hospital or qualified medical practitioner to disclose "general information on the condition of a person or patient unless that

[238] See S. Freedman, "Medical Privilege" (1954) 32 Can. Bar Rev. 1 at 16 for further discussion on the relationship between health care professionals and patients about implied consent to disclosure of patient health information.

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person or patient directs otherwise." The Manitoba *Personal Health Information Act*,[239] at section 23, is more detailed. As long as not contrary to the express request of a health care facility patient or resident, or that person's representative, the keeper of health records may disclose to anyone certain specified details about the patient or resident. A person's name, general health status, and location may be revealed. Location is not to be disclosed, though, where this would reveal specific information about a person's physical or mental condition. More generally, personal health information is not to be revealed if the keeper of the records has reason to believe that disclosure might lead to physical or mental harm of the subject of the personal health information.

Different perspectives exist concerning the sharing with third parties of general health information about a person or patient who is at a facility. Some people may object to the sharing of any details. Others might object to providing details to some groups, such as employers or the media, but agree that family members and friends should be entitled to certain information. There may also be a concern that to make mental health information a special category might further serve to stigmatize mental illness.

For the protection of personal privacy, the Commission supports the current Nova Scotia approach, that access to a person's mental health record should in general only be permitted with a person's consent. The Commission generally agrees with how this issue has been dealt with in the *Hospitals Act*, including the specified exceptions. To accommodate the widest range of perspectives possible, the Commission suggests that subsection 71(7), which allows for the disclosure of general information on the condition of a person or patient, unless that person or patient objects, should be retained. This provision allows a person or patient to set limits on who is entitled to receive certain general details concerning the individual's health. If, however, a person or patient chooses not to mention the matter, then family members and other concerned people could have access to basic details in order to lessen their potential worries. The Commission is not of the view that subsection 71(7) should attempt to list all the types of people entitled to general information, as a potentially large and unforeseeable number could be involved.

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[239] Note 225, above.

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- There is no need to attempt to list all the types of people entitled to general information about a person or patient at a facility.

c) Should there be limited disclosure to other non-medical agencies or facilities?

Subsection 71(6) of the *Hospitals Act* permits the transfer of patient information between hospitals. Nothing is said about providing necessary information to non-medical agencies or facilities with which a patient could have involvement.

One example might be a patient entrusted to law enforcement or corrections officials, for the purpose of a transfer between facilities. In 1996, Richard Albert Clarke, a 26 year-old man, died at the Nova Scotia Hospital. At the time of his death, Mr. Clarke was the subject of an order of the Provincial Court at New Glasgow requiring him to enter the Forensic Unit of the Nova Scotia Hospital in Dartmouth for a psychiatric assessment. The fatality inquiry concerning Mr. Clarke's death found that the transfer of information about Mr. Clarke from the Aberdeen Hospital in New Glasgow and its medical staff through peace officers and sheriffs to the Nova Scotia Hospital was "woefully lacking."[240] The Inquiry Report recommended that "[t]he Joint Committee on Forensic Services develop a protocol to facilitate the transfer of information [such as] ... the circumstances which led to the arrest of the individual, known persons or institutions providing care or treatment, known diagnosis (provisional or otherwise), allergies and medications...."[241]

Another concern raised relates not to protection of a patient, either in terms of privacy or health, but to protection of third parties. If a patient is considered to be a threat to others, then leaving that person in the care of a non-medical establishment without indicating the patient's potential for dangerousness could subject others to the risk of harm.

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[240] *In the Matter of an Inquiry into the Cause of the Death of Richard Albert Clarke, on November 10, 1996 at Dartmouth, Halifax County, Nova Scotia* (24 July 1998) (N.S. Prov. Ct.).

[241] Note 240, above, at 11.

In Manitoba, personal health information may be disclosed to any person if the keeper of the record reasonably believes that disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual the information is about, another individual, or public health or safety.[242]

The Commission is of the view that in this context, risks, not only to a patient but as a result of a patient, should be made known to officials at a non-medical establishment to which a patient is being transferred. To prevent risks, the relevant portion of a patient's health care record should be transferred along with a patient. The Commission takes the position that a provision equivalent to that from the Manitoba statute would address the need to transfer information concerning a patient in certain appropriate situations. As a result, the Commission suggests that in Nova Scotia, the disclosure of the relevant portion of the patient's health care record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or public safety.

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d) Should the statute include search warrants?

Subsection 71(5) of the *Hospitals Act* specifies who may receive hospital records and particulars concerning a person or patient currently or formerly in the hospital:

> *a) a person on the staff of the hospital for hospital or medical purposes;*
> *b) the qualified medical practitioner of the person concerned designated by the person as his physician;*
> *c) a person authorized by court order or subpoena;*
> *d) a person or agency otherwise authorized by law;*
> *e) the Minister or any person or agency designated or authorized by the Minister.*

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[242] Note 225, above, s. 22.

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Although conceivably falling under clauses c) or d), above, search warrants are not specifically mentioned in the *Act*. A search warrant is an order, issued by a judge or justice of the peace, authorizing a named person to enter a certain place to search for and seize particular property which will provide evidence of the intended or actual commission of a crime.[243] Some peace officers have suggested that fulfillment of their duties would be facilitated by having search warrants included in subsection 71(5).

The Commission is of the view that mental health information might legitimately be sought as part of a search warrant issued to law enforcement authorities. The Commission suggests that the *Hospitals Act* be clarified, by specifically allowing for the disclosure of hospital records and particulars coming within the scope of a search warrant issued to law enforcement authorities.

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- The *Hospitals Act* should specifically allow for the disclosure of hospital records and particulars coming within the scope of a search warrant issued to law enforcement authorities.

2. Accuracy, correction and amendment of health records

Should there be a statutory right to correct or amend health records?

The mental health statutes in the majority of provinces and territories allow people to have information corrected in their health records. These provisions seem to be based on the ULCC *Uniform Mental Health Act*.[244] The Nova Scotia *Hospitals Act* does not include a statutory right of correction or amendment.[245]

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[243] Dukelow & Nuse, note 102, above, at 962.

[244] Note 108, above.

[245] The Canadian Medical Association's *Health Information Privacy Code*, note 227, above, also addresses this issue:

> *7.3 Patients who have reviewed their information and believe it to be inaccurately recorded or false have the right to suggest amendments and to have their amendments appended to the health information.*

Subsection 29(7) of the ULCC *Act* allows a person who is permitted to examine his or her record to request a correction of information in the record, if the person believes that it contains an error or omission. If the requested correction is not made, then the person is entitled to have a statement of disagreement attached to the record, reflecting the nature of the correction requested but not made. The person is also entitled to have notice of the correction or statement of disagreement given to any person or organization to whom the record was disclosed within the previous year.

The Commission takes the position that in the interest of fairness, those patients entitled to view their mental health care records should be able to indicate their disagreement with any details in the record. As a result, the Commission suggests that the *Hospitals Act* should contain a section equivalent to subsection 29(7) of the ULCC *Act*. This section would permit a patient, otherwise entitled to view his or her record, to require that corrections be made, or statements of disagreement be added, to a record. The section would also require notice of the correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

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- The *Act* should also require notice of any correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

3. Interaction of privacy legislation with health records

In addition to mental health and public hospital statutes, access to records held by certain institutions, agencies or government departments may also be covered by freedom of information and protection of privacy legislation. This legislation attempts to balance two interests. It sets out procedures whereby individuals can obtain access to information that is in the possession of public bodies.[246] In the interest of personal privacy, the legislation also provides limits on who can access certain information and for what reasons.

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[246] In addition to providing access to hospital records, freedom of information legislation can also include procedures for responding to a belief that there is an error or omission in a record. See Hobart, note 230, above, at 85-112 for an overview of privacy legislation and its interaction with personal health information.

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The federal as well as provincial and territorial governments share responsibilities for the protection of privacy in Canada. Current legal protection of privacy represents a patchwork of various laws, policies, regulations and voluntary codes of practice.[247] At the federal level, the *Privacy Act*[248] applies to the protection of privacy in the public sector. Patient-identifiable health information which is collected by Statistics Canada is protected under the *Statistics Act*.[249] Parliament recently enacted the *Personal Information Protection and Electronic Documents Act*.[250] Scheduled to come into effect on January 1, 2001, this legislation is meant to balance the need to protect personal information collected in the private sector with the legitimate information needs of the private sector. The privacy provisions of this statute will not affect the health care sector for an additional year after the statute comes into force.[251] Eight provinces and three territories have also enacted legislation protecting personal information in the public sector.[252] Until recently, only Quebec guaranteed privacy in both the private and public sectors.[253] Manitoba and Alberta have recently created legislation specifically meant to protect personal health information. The Alberta statute will have some application to the private health sector.[254]

This type of legislation is not without critics, however. The Canadian Medical Association (CMA) expressed serious concern about the privacy implications of the new federal privacy legislation.[255] CMA stressed that any laws relating to health information must recognize patient privacy and the confidentiality of the patient record as its two dominant priorities. The

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[247] Health Canada, Office of Health and the Information Highway, "Telehealth - Protection of Personal Health Information," online: <http://www.hc-sc.gc.ca/ohih-bsi/tele/protpers_e.html> (last modified: 23 March 2000).

[248] R.S.C. 1985, c. P-21.

[249] R.S.C. 1985, c. S-19.

[250] S.C. 1999, c. 5.

[251] Note 250, above, s. 30.

[252] Note 247, above [figures from source changed to include Nunavut].

[253] Note 247, above.

[254] Although the Alberta statute, note 226, above, does not cover the private sector generally, it does, for instance, define a records "custodian" at s. 1 to include "a health services provider who is paid under the Alberta Health Care Insurance Plan to provide health services."

[255] Canadian Medical Association, "Canadians Highly Value the Privacy and Confidentiality of their Health Information," online: CMA Web site <http://www.cma.ca/advocacy/news/1999/11-29.htm> (date accessed: 26 May 2000).

Association has also proposed that the legislation should be consistent with the CMA's *Health Information Privacy Code*.[256]

The relevant privacy legislation in British Columbia has been used by a former psychiatric patient to gain access to his medical records.[257] By contrast, Manitoba's *Freedom of Information and Protection of Privacy Act* expressly does not apply to clinical records governed by that province's mental health statute.[258]

It does not appear that the *Freedom of Information Act and Protection of Privacy Act* (FOIPOP)[259] has been used by a Nova Scotia patient to gain access to his or her hospital record.[260] Until recently in Nova Scotia there was some question as to whether or not FOIPOP would override the privacy provisions at section 71 of the *Hospitals Act*. This matter was clarified in November 1999 when FOIPOP was amended to make it clear that in the event of a conflict between the *Hospitals Act* and FOIPOP, the *Hospitals Act* sections will prevail.[261] Similar to the *Hospitals Act* and other public hospital statutes or mental health statutes, freedom of information legislation only applies to public bodies such as hospitals and publicly funded health clinics, and not to private physician offices or clinics.

An issue is whether the Nova Scotia legislation should consolidate the statutory and common law exceptions to the general duty to maintain confidentiality. Some people suggest that health care information could be used for improper purposes. These people point to the sharing of personal health care information among government agencies as an area for concern. Others are of the view that though a patient in general has control over access to his or her personal health details, some sharing among government agencies is appropriate, in particular to help ensure a fair allocation of resources. Another issue in this area is whether health information legislation should also apply to details in the possession of private facilities and psychiatrists' offices.

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[256] Note 227, above. The Privacy Code is based on ten principles, including: recognition of the patient's right to privacy; limits on the collection, use, disclosure and access to this information; security safeguards; and accountability first and foremost to the patient.

[257] *Re Minister of Health and Information and Privacy Commissioner of British Columbia* (1997), 150 D.L.R. (4th) 562 (B.C.S.C.).

[258] *Mental Health and Consequential Amendments Act*, S.M. 1998, c. 36, s. 39.

[259] S.N.S. 1993, c. 5.

[260] Telephone conversation with Mr. Bob Doherty, Co-ordinator for *Freedom of Information and Protection of Privacy Act*, N.S. Dept. of Justice (24 September 1999). Mr. Doherty indicated that since there is an established statutory procedure under the *Hospitals Act* for access to hospital records, patients were encouraged to use that route.

[261] S.N.S. 1999 (2nd Sess.), c. 11, s. 4(5).

The Commission acknowledges that complex issues are present in this area. Given the number and nature of the issues involved, which affect other areas of law besides mental health law, the Commission takes the position that issues involving the ownership and use of personal health care information should form the subject of a separate study.

The Commission suggests:

- Issues involving the ownership and use of personal health care information should form the subject of a separate study.

F. OTHER ISSUES

1. "Least restrictive" and "least intrusive" principles

Should the principles of "least restrictive" and "least intrusive" be included?

Some mental health legislation refers to services being provided in a "least restrictive" or "least intrusive" fashion. These general principles can take the form of a preamble or of purpose clauses. A preamble is a preface which states the reasons for and intended effects of a statute.[262] It can be used to assist in explaining the meaning and aim of legislation.[263] A purpose clause or declaration of purpose has a similar role,[264] but is contained within the body of a statute. The Northwest Territories and Nunavut statutes in their preambles express a commitment to the principle that mental health services should be provided in the least restrictive manner.[265] In its 1995 report on adult guardianship and advance health care directives, the Commission recommended the adoption of a "least restrictive" approach in the context of guardianship orders.[266]

Among those people who believe that the *Act* would benefit from the inclusion of certain limits on the nature of mental health services, there seems to be considerable disagreement about

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[263] *Interpretation Act*, R.S.N.S. 1989, c. 235, s. 11(1).

[264] Côté, note 262, above, at 55.

[265] See also *Mental Health Act*, S.A. 1988, c. M-13.1, ss. 28(4)(d), 29(3)(b)(iv); ULCC statute, note 108, above, s. 2.

[266] Note 171, above, at 27-28, 32.

what principles would be appropriate. Options include "least restrictive," "least intrusive," "least onerous," "most therapeutic," "best possible," and "best interests." Not all of these terms are compatible. For instance, one type of medication, taken in oral form, could be less intrusive, but also less effective, and therefore less therapeutic, than one administered through an injection.

The Commission is of the view that to insert unduly broad principles into the legislation would create the potential for confusion. The Commission also points out that some general principles may not be appropriate in all contexts. Rather than incorporating general principles, which could lead to a lack of clarity and consistency, the Commission takes the position that sections of an amended *Hospitals Act* should stand on their own. As a result, the Commission is not in favour of adopting any general principles, either in the form of a preamble or purpose clauses, to apply to the entire *Act*.

The Commission suggests:

- There is no need to insert general principles, either in the form of a preamble or purpose clauses, into the *Act*.

2. A new or an amended statute

What form should changes to the law take?

This Paper identifies a number of aspects of the *Hospitals Act* which are in need of reform. It also suggests that many sections of the statute are satisfactory and are not in need of change. As much of the current statute could be retained, the Commission's suggested reforms could be implemented in the form of amendments to the existing *Hospitals Act*, rather than through its complete replacement by a new *Act*. Having said this, the Commission points to some of its earlier reports and notes that it might be appropriate to make changes to the *Hospitals Act* as part of a wider legislative initiative. In 1995, the Commission proposed changes to the law governing adult guardianship and advance health care directives.[267] In 1999, the Commission made recommendations concerning enduring powers of attorney.[268] The 1995 and 1999 reports also involved mental health law, namely how decisions are to be made concerning a person's health and well-being or property when that person lacks the capacity to completely manage his or her own affairs. To promote consistency, clarity, and efficiency in aspects of mental

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[267] Note 171, above.

[268] Law Reform Commission of Nova Scotia, *Enduring Powers of Attorney* (Final Report) (Halifax: The Commission, 1999).

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[266] Note 171, above, at 27-28, 32.

what principles would be appropriate. Options include "least restrictive," "least intrusive," "least onerous," "most therapeutic," "best possible," and "best interests." Not all of these terms are compatible. For instance, one type of medication, taken in oral form, could be less intrusive, but also less effective, and therefore less therapeutic, than one administered through an injection.

The Commission is of the view that to insert unduly broad principles into the legislation would create the potential for confusion. The Commission also points out that some general principles may not be appropriate in all contexts. Rather than incorporating general principles, which could lead to a lack of clarity and consistency, the Commission takes the position that sections of an amended *Hospitals Act* should stand on their own. As a result, the Commission is not in favour of adopting any general principles, either in the form of a preamble or purpose clauses, to apply to the entire *Act*.

The Commission suggests:

- There is no need to insert general principles, either in the form of a preamble or purpose clauses, into the *Act*.

2. A new or an amended statute

What form should changes to the law take?

This Paper identifies a number of aspects of the *Hospitals Act* which are in need of reform. It also suggests that many sections of the statute are satisfactory and are not in need of change. As much of the current statute could be retained, the Commission's suggested reforms could be implemented in the form of amendments to the existing *Hospitals Act*, rather than through its complete replacement by a new *Act*. Having said this, the Commission points to some of its earlier reports and notes that it might be appropriate to make changes to the *Hospitals Act* as part of a wider legislative initiative. In 1995, the Commission proposed changes to the law governing adult guardianship and advance health care directives.[267] In 1999, the Commission made recommendations concerning enduring powers of attorney.[268] The 1995 and 1999 reports also involved mental health law, namely how decisions are to be made concerning a person's health and well-being or property when that person lacks the capacity to completely manage his or her own affairs. To promote consistency, clarity, and efficiency in aspects of mental

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[267] Note 171, above.

[268] Law Reform Commission of Nova Scotia, *Enduring Powers of Attorney* (Final Report) (Halifax: The Commission, 1999).

health law, the Commission suggests that changes to the *Hospitals Act* should be undertaken as part of a wider statute which addresses mental health issues generally. In the interest of achieving reform, however, if the creation of a wider mental health statute would involve undue delay, then the Commission suggests that its proposals should take the form of amendments to the current *Hospitals Act*.

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IV SUMMARY OF SUGGESTIONS

A. ADMISSION TO MENTAL HEALTH FACILITIES

1. **Involuntary examination and assessment** [pages 20 - 22]

- The current wording of the *Hospitals Act*, which at subsection 36(2) requires "reasonable and probable grounds" for admission as a person under observation, but a higher standard for admission as an involuntary patient, should be retained.

- An assessment should be completed as quickly as possible, in compliance with professional standards.

- The standard time period for completion of an assessment should be 24 hours, with a possibility for an additional 48 hours in exceptional cases.

2. **Pursuant to medical certificates** [pages 22 - 26]

- The *Hospitals Act* should continue to allow for the involuntary admission of a person for observation on the basis of two medical certificates provided by physicians, or one certificate in compelling circumstances.

- The possibility of detention and examination by a judicial order under the *Hospitals Act*, though not the primary route for admission, should be retained.

3. **Criteria** [pages 26 - 32]

- The term "mental disorder" should be used rather than "psychiatric disorder."

- "Mental disorder" should be defined as a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.

- The Commission seeks comments on what, if any, conditions should be specifically mentioned in the definition of mental disorder.

- The majority of the Commission suggests that the Nova Scotia legislation should allow for the involuntary admission of someone with a mental disorder not only when bodily harm is likely to self or others, but also when there is a likelihood of causing psychological harm to self.

- The majority of the Commission suggests that the statute should include a provision relating to a person's "imminent and serious impairment" as part of the criteria for involuntary admission.

- Neither harm to property nor finances should be available as a ground for a person's involuntary admission to a facility.

- The *Hospitals Act* should make clear the need for a causal relationship between a mental disorder and a danger to self or others.

4. **Peace officers** [pages 32 - 36]

- Clause 38(1)(b) of the *Hospitals Act*, which provides for the apprehension of a disordered person "committing or about to commit an indictable offence," is not necessary and should be removed.

- Peace officers should be permitted to leave a facility during the time that a person apprehended and brought in by the officers is being assessed. To avoid any misunderstandings, consent for peace officers to depart a facility should be in writing.

- The majority of the Commission suggests that facility staff should be required to inform peace officers when a psychiatric assessment of a person brought to a facility by peace officers is completed and the person is not admitted as an involuntary patient.

- Copies of relevant police reports should be included in a patient's psychiatric file.

5. **Detention periods** [pages 36 - 39]

- The current initial detention period of one month for an involuntary patient should be retained.

- A declaration of formal admission should be renewable for a one month period, followed if needed by a two month period, in turn followed by a three month period. Any additional renewal periods would be for three months.

- Unless no other psychiatrist is available, an examination for the purpose of a renewal certificate should continue to be completed by a psychiatrist who was not involved in the initial admission certificate or a prior renewal certificate.

- The responsibility for renewal examinations should remain with psychiatrists.

- Any disputes involving the nature or duration of renewals should be heard by the review board.

B. TREATMENT

1. Mental capacity to consent to treatment [pages 39 - 43]

- The *Hospitals Act* should state explicitly that every person is considered capable of making treatment decisions, until the contrary is determined.

- A capacity determination should take place only when an issue arises about a patient's capacity.

- The factors at subsection 52(2) of the *Hospitals Act,* which a psychiatrist must consider in determining a person's capacity to consent to treatment, should remain unchanged.

- In addition to psychiatrists, other specially qualified health care professionals should be permitted to complete capacity assessments. Organizations of health care professionals should determine what combination of training and experience would meet the required qualifications.

2. Informed consent [pages 43 - 45]

- The *Hospitals Act* should require that prior to receiving a particular treatment, a patient must provide his or her informed consent. This would mean that the patient was informed about the nature of the treatment, its expected benefits, its material risks, its material side effects, any alternative courses of action, and any likely consequences of not having the treatment.

- The elements of informed consent should be set out in any standard forms used in compliance with the *Act*.

3. Consent to treatment and compulsory treatment [pages 45 - 51]

- The majority of the Commission suggests that in those situations for which a person has not appointed a proxy through an advance health care directive, it should be possible for a review board to approve compulsory treatment if the person has become mentally incapable. Before authorization, the review board must be satisfied that the mental condition of the patient will either be substantially improved by the treatment or will

not improve without the treatment and that the benefit to the patient will outweigh the potential risk of harm.

- The *Hospitals Act* should define routine clinical medical treatment, with extraordinary types of treatment to be approved by a review board.

- Routine clinical medical treatment should be defined as "generally recognized and acceptable psychiatric treatment and other generally recognized and acceptable medical treatment that is necessary to effectively treat a mental disorder."

- A substitute decision-maker should be required to take into account any prior expressed wishes by a person. If there are no prior expressed wishes, or if they are unclear, then a substitute decision-maker should take a person's best interest into account.

- In the event of a dispute between substitute decision-makers of the same rank, either a substitute decision-maker or the treating psychiatrist could apply to the review board, in order to have the dispute resolved.

4. **Emergency exception to consent requirement** [pages 51 - 53]

- The statute should specifically allow for treatment to be administered without consent to a person who is incapable with respect to consent to the treatment if there is an "emergency."

- An "emergency" should be found to exist if the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

5. **Use of restraints** [pages 53 - 55]

- Restraint should involve keeping a patient under control to prevent harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient.

- Detailed records should be kept of the type of restraint used. The details, to be made part of a patient's clinical record, should include such information as the date and duration of restraint, the behaviour leading to the use of restraint, and in the event of chemical restraint, the type, administration, and dosage of the chemical used.

- The *Hospitals Act* should include a clause exempting from liability for the use of restraint any person acting reasonably and in good faith in the course of his or her duties under the *Act*.

6. **Advance health care directives** [pages 55 - 57]

- The majority of the Commission suggests that where a person is no longer mentally capable, certain compelling circumstances, such as medical developments not available at the time an advance health care directive was created, may justify not following the advance health care directive.

- The Commission invites comments on what other compelling circumstances might justify not following an advance health care directive.

7. **Office of Public Trustee** [pages 57 - 58]

- The Public Trustee's role in relation to consent to treatment could best be considered as part of a project examining all the duties and responsibilities of the Public Trustee.

8. **Provision of mental health treatment in the community: "community treatment orders" and "leave certificates"** [pages 58 - 62]

- Leave certificates should be made available in Nova Scotia for certain involuntary patients.

- In order for a leave certificate to be issued, the patient must be suffering from a mental disorder for which he or she needs continuing treatment or care and supervision while living in the community. The patient must be considered likely, because of the mental disorder, to cause bodily harm to self or others, to cause psychological harm to self, or to suffer imminent and serious impairment if the patient does not receive continuing treatment or care and supervision while living in the community.

- A collaborative treatment plan must be developed, to which the patient or the patient's representative consents. The patient must be capable of complying with the leave certificate requirements. The treatment or care and supervision described in the leave certificate must exist in the community and can and will be provided in the community.

C. PATIENTS' PROPERTY AND FINANCES

1. Mental competence to administer one's estate [pages 62 - 64]

- A competency determination should take place only when an issue arises about a patient's competency to administer his or her estate.

- The factors to be considered in determining a person's competency to administer his or her estate should remain unchanged.

- In addition to psychiatrists, suitably qualified health care professionals from outside the psychiatric profession should be permitted to perform competency determinations.

2. Office of Public Trustee [pages 65 - 66]

- When the estate of a patient in a facility is in need of supervision and no other person is available, intervention by the Public Trustee should be mandatory. Sufficient resources should be allocated to the Public Trustee's Office to enable it to fulfil its important role with worrying about the ability of some estates to pay.

D. REVIEW AND APPEAL

1. Composition of review boards [pages 66 - 67]

- The composition of a review board need not be defined in the *Act*.

- Training should be provided for all review board appointees. Training should include an introduction to mental health concepts and issues which might likely arise as part of a review board hearing. Training should also include the requirements of natural justice, fairness, human rights law, and modern caseflow management practices.

2. Review applications [pages 68 - 70]

- For the most part, the list at subsection 65(1) of the *Act* of those who can request a review of a patient's file should remain unchanged. The wording should be amended, though, to take into account the fact that there is no "administrator of psychiatric services."

- A patient under the legislated age of majority should also be able to apply for a review.

- In relation to treatment and care, review boards for the most part should continue to provide only non-binding recommendations. A review board should, however, be able to approve compulsory treatment for a person who has not made an advance health care directive and who has become mentally incapable. A review board would also have to approve extraordinary types of treatment.

3. **Limitation on frequency of review applications** [pages 70 - 71]

- The limit on the frequency of review applications should be shortened to three months.

4. **Timing of hearing a review application** [pages 71 - 72]

- A review board should hear a review application as soon as the board is able to do so and in any event, within 21 calendar days of the application being received.

5. **Mandatory reviews** [pages 72 - 73]

- There should be a mandatory review of a patient's file every six months.

- Once undertaken, a mandatory review should be completed as expeditiously as possible.

6. **Procedure at review board hearings** [pages 73 - 79]

- An oral hearing should be held whenever a review board considers an application for review.

- The *Hospitals Act* should define in a general fashion who is entitled to attend a review hearing. The review board should have the discretion to determine whether a person has the necessary or legitimate interest in order to attend. The patient and the relevant facility would automatically receive notice of a hearing.

- When a review hearing will involve a minor, notice should be sent not only to the minor, but also to the minor's parents or guardian.

- A review board may refuse to hold a hearing if a previous application by the same patient was made too recently. Three months should have to elapse between reviews requested by a patient.

- The law should not prevent a review board member from participating in a hearing if he or she has already taken part in a hearing concerning the same patient.

- The wording of the current *Act* at subsection 62(3), which prevents a review board member from participating in the review of a patient, client, or relative of that review board member, should remain unchanged.

- Review boards should provide written reasons for their decisions.

- A decision should be communicated to the parties involved as soon as possible, and in any event, no later than within 14 calendar days of the hearing.

- The review board should not be empowered to require a patient's appearance at a hearing.

7. **Mandatory legal representation** [pages 80 - 81]

- The Commission invites comments on whether patients should be entitled to mandatory legal representation at a review board hearing, and if so, how this could best be provided.

8. **Right to advocacy services** [pages 81 - 82]

- The *Act* should provide for a rights adviser at each psychiatric facility.

- A rights adviser would be entrusted with the responsibility of explaining a matter pertaining to rights to the best of his or her ability in a manner that addresses the special needs of the person receiving the explanation.

- A rights adviser should be knowledgeable about rights of application to a review board, the nature and procedures of the review boards, and how to obtain legal services. A rights adviser would also require effective communication skills.

E. CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

1. **Use, accessibility and disclosure of health records** [pages 83 - 90]

- If a facility wishes to deny a patient access to his or her record, either in whole or part, then the *Hospitals Act* should require the facility to apply for a review board hearing, at

which the facility would have to convince the board why denial of access would be reasonable.

- The Commission invites comments on what mechanisms and procedures should be adopted to accommodate both the need for openness and the need to keep certain details confidential.

- Access to a person's mental health record should in general only be permitted with a person's consent. Subsection 71(7) of the *Hospitals Act*, which allows for the disclosure of general information on the condition of a person or patient unless that person or patient objects, should be retained.

- There is no need to attempt to list all the types of people entitled to general information about a person or patient at a facility.

- The disclosure of the relevant portion of the patient's health care record should be possible to any person if the keeper of the record reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the individual who is the subject of the information, another individual, or public health or safety.

- The *Hospitals Act* should specifically allow for the disclosure of hospital records and particulars coming within the scope of a search warrant issued to law enforcement authorities.

2. **Accuracy, correction and amendment of health records** [pages 90 - 91]

- The *Hospitals Act* should permit a patient, otherwise entitled to view his or her record, to require that corrections be made, or statements of disagreement be added, to a record.

- The *Act* should also require notice of any correction or statement of disagreement to be provided to persons or organizations to whom access to the record had been granted within the previous year.

3. **Interaction of privacy legislation with health records** [pages 91 - 94]

- Issues involving the ownership and use of personal health care information should form the subject of a separate study.

F. OTHER ISSUES

1. "Least restrictive" and "least intrusive" principles [pages 94 - 95]

- There is no need to insert general principles, either in the form of a preamble or purpose clauses, into the *Act*.

2. A new or an amended statute [pages 95 - 96]

- To promote consistency, clarity, and efficiency in aspects of mental health law, the Commission suggests that changes to the *Hospitals Act* should be undertaken as part of a wider statute which addresses mental health issues generally.

- If the creation of a wider mental health statute would involve undue delays, then the Commission's proposals should take the form of amendments to the current *Hospitals Act*.